IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BELMONT ABBEY COLLEGE
100 Belmont-Mt. Holly Rd.
Belmont, NC 28012;
Plaintiff,

Civ. Action No. _____

v.

COMPLAINT

KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services,

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

THOMAS PEREZ, Secretary of the United States Department of Labor,

UNITED STATES DEPARTMENT OF LABOR,

JACOB LEW, Secretary of the United States Department of the Treasury, and

UNITED STATES DEPARTMENT OF THE TREASURY,
Defendants.

VERIFIED COMPLAINT
(TRIAL BY JURY DEMANDED)

Plaintiff Belmont Abbey College, by and through its attorneys, alleges and states as follows:

NATURE OF THE ACTION

1. This is a challenge to regulations issued under the 2010 Patient Protection and Affordable Care Act that force employee health insurance plans to provide free coverage of contraceptives, sterilizations, and drugs and devices that cause early abortions (the "Final Mandate").

2. Plaintiff Belmont Abbey College is a private Catholic college founded and operated by Benedictine monks. The College "finds its center in Jesus Christ."[1] Belmont Abbey College is "guided by the Catholic intellectual tradition and the Benedictine spirit of prayer and learning," and its mission is "to educate students in the liberal arts and sciences so that in all things God may be glorified." *See id.*

3. Consistent with traditional Catholic teaching on the sanctity of life and sexuality, Belmont Abbey College believes and teaches that abortion, sterilization, and the use of contraceptives to prevent pregnancy are morally unacceptable. Belmont Abbey College's religious convictions forbid it from participating in, paying for, designating others to pay for, training others to engage in, or otherwise supporting or facilitating access to, contraception, sterilization, or abortion.

4. In light of these religious beliefs, Belmont Abbey College cannot participate in the government's regulatory scheme to promote, encourage, and subsidize the use of sterilization,

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[1] *See* Belmont Abbey, President Home, Vision Statement, http://www.belmontabbeycollege.edu/president/vision-statement.aspx (last visited Oct. 29, 2013).

contraceptives, and drugs and devices that cause abortions. Under the Final Mandate, however, Belmont Abbey College faces millions of dollars in fines for this religious exercise.

5. The government defendants have exempted thousands of plans, covering tens of millions of employees, from the Final Mandate. These exemptions have been granted for a wide variety of reasons, from the purely secular exemption for plans in existence before a certain date ("grandfathered plans") to a narrow religious exemption for certain "religious employers."

6. Despite its obvious religious nature, and despite the fact that Belmont Abbey College is still operated in part by an order of Benedictine monks, Belmont Abbey College does not qualify for any exemptions. While "religious employers" are exempted, Defendants have limited that exemption to protect only "churches, their integrated auxiliaries, and conventions or associations of churches" and "the exclusively religious activities of any religious order." That is because, in the eyes of the government, the monks' work educating students in "the Catholic intellectual tradition and the Benedictine spirit of prayer and learning" is not an "exclusively religious activity."

7. The regulations do offer Belmont Abbey College and other non-exempt religious organizations what the defendants have labeled an "accommodation." But the "accommodation" still requires Belmont Abbey College to play a central role in the government's scheme, because it must designate an agent to pay for the objectionable services on Belmont Abbey College's behalf, and it has to take steps to trigger and facilitate that coverage. Belmont Abbey College cannot take these actions to facilitate this coverage without violating its religion.

8. The supposed "accommodation" also continues to treat Belmont Abbey College as a second-class religious organization, not entitled to the same religious freedom rights as other

religious organizations, including any religious schools that are "integrated auxiliaries" of churches.

9. The "accommodation" also creates administrative hurdles and other difficulties for Belmont Abbey College, forcing it to seek out and contract with companies willing to provide the very drugs and services it speaks out against.

10. If Belmont Abbey College does not compromise its religious convictions and comply with the regulations, however, it faces severe penalties that could exceed $7.6 million each year.

11. By placing Belmont Abbey College in this impossible position, Defendants have violated the Religious Freedom Restoration Act, as well as the Free Exercise, Establishment, and Free Speech Clauses of the First Amendment of the United States Constitution, The Due Process Clause of the Fifth Amendment, and the Administrative Procedure Act.

12. Belmont Abbey College therefore respectfully requests declaratory and permanent injunctive relief.

JURISDICTION AND VENUE

13. The Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 and § 1361. This action arises under the Constitution and laws of the United States. This Court has jurisdiction to render declaratory and injunctive relief under 28 U.S.C. §§ 2201 and 2202, and 42 U.S.C. § 2000bb-1.

14. Venue lies in this district pursuant to 28 U.S.C. § 1391(e). A substantial part of the events or omissions giving rise to the claim occurred in this District, and the Defendants are located in this District.

IDENTIFICATION OF PARTIES

15. Plaintiff Belmont Abbey College is a private Catholic Benedictine College in Belmont, North Carolina. Founded by an order of monks in 1876, Belmont Abbey College finds its center in Jesus Christ and seeks to provide an educational environment in which the principles of Holy Scripture as taught by the Catholic Church are held up as an ideal.

16. Defendants are appointed officials of the United States government and United States governmental agencies responsible for issuing the Mandate.

17. Defendant Kathleen Sebelius is the Secretary of the United States Department of Health and Human Services ("HHS"). In this capacity, she has responsibility for the operation and management of HHS. Sebelius is sued in her official capacity only.

18. Defendant HHS is an executive agency of the United States government and is responsible for the promulgation, administration and enforcement of the Mandate.

19. Defendant Thomas Perez is the Secretary of the United States Department of Labor. In this capacity, he has responsibility for the operation and management of the Department of Labor. Secretary Perez is sued in his official capacity only.

20. Defendant Department of Labor is an executive agency of the United States government and is responsible for the promulgation, administration, and enforcement of the Mandate.

21. Defendant Jacob Lew is the Secretary of the Department of the Treasury. In this capacity, he has responsibility for the operation and management of the Department. Secretary Lew is sued in his official capacity only.

22. Defendant Department of Treasury is an executive agency of the United States government and is responsible for the promulgation, administration, and enforcement of the Mandate.

FACTUAL ALLEGATIONS

I. Belmont Abbey College's Religious Beliefs and Practices Related to Insurance for Contraception, Sterilization, and Abortion.

23. Belmont Abbey College is a small liberal arts school located outside of Charlotte, North Carolina. It was founded in 1876 by a congregation of Benedictine monks, who built the campus with bricks they formed by hand from the red clay of the North Carolina soil.

24. Today, the monastery operates in the center of campus, and the monks of the Abbey continue to live on Belmont Abbey College's campus and sponsor it. They provide significant financial support for Belmont Abbey College, and the monks also serve on the Board of Trustees that governs Belmont Abbey College. The head of the monastery, Abbot Placid Solari, serves as Belmont Abbey College's Chancellor, and other monks serve as teachers, administrators, and chaplains.

25. Faith is central to the educational mission of Belmont Abbey College. Belmont Abbey College describes itself as a Catholic Benedictine College that "finds its center in Jesus Christ" and is "led by St. Benedict's desire 'that in all things God may be glorified.'"[2]

26. Belmont Abbey College's purpose is expressed in its mission statement: "Our mission is to educate students in the liberal arts and sciences so that in all things God may be glorified. In this endeavor, we are guided by the Catholic intellectual tradition and the Benedictine spirit of prayer and learning. Exemplifying Benedictine hospitality, we welcome a diverse body of students and provide them with an education that will enable them to lead lives of integrity, to

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[2] Belmont Abbey, President Home, Vision Statement, http://www.belmontabbeycollege.edu/president/vision-statement.aspx (last visited Oct. 29, 2013).

succeed professionally, to become responsible citizens, and to be a blessing to themselves and to others."[3]

27. Belmont Abbey College adheres to the Apostolic Constitution *Ex Corde Ecclesiae* of Pope John Paul II, which is the relevant law of the Roman Catholic Church for Catholic colleges and universities.[4]

28. *Ex Corde Ecclesiae* requires all Catholic universities to have among its "*essential characteristics* . . . fidelity to the Christian message as it comes to us through the Church." Accordingly, Belmont Abbey College strives to reflect "[f]idelity to the Christian message as it comes to us through the Church" in all aspects of its teaching.[5]

29. *Ex Corde Ecclesiae* also requires Catholic universities to reflect "[a] Christian inspiration . . . of the whole college community." *Id.* Accordingly, Abbot Placid interviews all prospective faculty members to discover how they will make Belmont Abbey College's vision of "find[ing] our center in Jesus Christ" apparent in their teaching, and how they will further Belmont Abbey College's mission of being a Catholic and Benedictine college. *Id.*

30. As a Catholic institution, Belmont Abbey College holds religious beliefs that include traditional Catholic teachings on the sanctity of life. Belmont Abbey College believes and teaches that each human being bears the image and likeness of God, and therefore that all human

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[3] Belmont Abbey College, Mission Statement, http://www.belmontabbeycollege.edu/visionstatement/mission-statement.aspx (last visited Oct. 29, 2013).

[4] *See* Pope John Paul II, Apostolic Constitution on Catholic Universities (1990), http://www.vatican.va/holy_father/john_paul_ii/apost_constitutions/documents/hf_jp-ii_apc_15081990_ex-corde-ecclesiae_en.html.

[5] Belmont Abbey College, Abbott Placid Solari, http://www.belmontabbeycollege.edu/chancellor/interview.aspx (last visited Oct. 29, 2013).

life is sacred and precious, from the moment of conception. Belmont Abbey College therefore believes and teaches that abortion ends a human life and is a grave sin.

31. Belmont Abbey College's religious beliefs also include traditional Catholic teaching on the nature and purpose of human sexuality. In particular, Belmont Abbey College believes, in accordance with Pope Paul VI's 1968 encyclical, *Humanae Vitae*, that human sexuality has two primary purposes: "uniting husband and wife in the closest intimacy" and "for the generation and rearing of new lives."[6] Accordingly, Belmont Abbey College believes, with the Catholic Church, that "[t]o use this divine gift while depriving it, even if only partially, of its meaning and purpose, is equally repugnant to the nature of man and of woman, and is consequently in opposition to the plan of God and His holy will." *Id.* Therefore, Belmont Abbey College believes and teaches that "any action which either before, at the moment of, or after sexual intercourse, is specifically intended to prevent procreation—whether as an end or as a means"—including contraception and sterilization—is a grave sin.

32. Because of its religious convictions concerning the sanctity of life, Belmont Abbey College cannot participate in any scheme to facilitate access to drugs and services that cause abortions, sterilizations, or deliberately prevent a pregnancy.

33. Belmont Abbey College has approximately 1,600 students.

34. Belmont Abbey College has approximately 200 full-time and 130 part-time employees.

35. As part of its commitment to Catholic education, in accordance with Catholic social teaching, Belmont Abbey College also promotes the well-being and health of its students and employees. This includes provision of on-campus health services for its students and employees.

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[6] Pope Paul VI, Humanae Vitae (1968), http://www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae_en.html.

36. Also as a part of this religious commitment, Belmont Abbey College provides insurance policies to its full-time faculty and staff.

37. As part of its religious commitment, Belmont Abbey College ensures that its insurance policies do not cover drugs, devices, services or procedures inconsistent with its faith. In particular, its insurance plans do not cover sterilization, contraception, or abortion.

38. Belmont Abbey College's religious beliefs prohibit it from deliberately providing insurance coverage for drugs, devices, services or procedures inconsistent with its faith—in particular, sterilization, contraception, or abortion.

39. Nor would Belmont Abbey College's religious beliefs permit it to deliberately provide health insurance that would facilitate access to sterilization, contraception, or abortion, or related education and counseling—even if those items are paid for by an insurer or designee and not by Belmont Abbey College.

40. Many of Belmont Abbey College's employees and students choose to work at or attend Belmont Abbey College because they share its religious beliefs and wish to help Belmont Abbey College further its mission. Belmont Abbey College would violate their implicit trust in the organization and detrimentally alter its relationship with them if it were to violate its religious beliefs regarding abortion, sterilization, and contraceptives.

II. The Affordable Care Act and Preventive Care Mandate

41. In March 2010, Congress passed, and President Obama signed into law, the Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010), and the Health Care and Education Reconciliation Act, Pub. L. 111-152 (March 30, 2010), collectively known as the "Affordable Care Act."

42. The Affordable Care Act regulates the national health insurance market by directly regulating "group health plans" and "health insurance issuers."

43. One provision of the Act mandates that any "group health plan" or "health insurance issuer offering group or individual health insurance coverage" must provide coverage for certain preventive care services. 42 U.S.C. § 300gg-13(a).

44. The services required to be covered include medications, screenings, and counseling given an "A" or "B" rating by the United States Preventive Services Task Force;[7] immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and "preventive care and screenings" specific to infants, children, adolescents, and women, as to be "provided for in comprehensive guidelines supported by the Health Resources and Services Administration." 42 U.S.C. § 300gg-13(a)(1)-(4).

45. The statute specifies that all of these services must be provided without "any cost sharing." 42 U.S.C. § 300gg-13(a).

The Interim Final Rule

46. On July 19, 2010, HHS[8] published an interim final rule imposing regulations concerning the Affordable Care Act's requirement for coverage of preventive services without cost sharing. 75 Fed. Reg. 41726, 41728 (2010).

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[7] The list of services that currently have an "A" or "B" rating include medications like aspirin for preventing cardiovascular disease, vitamin D, and folic acid; screenings for a wide range of conditions such as depression, certain cancers and sexually-transmitted diseases, intimate partner violence, obesity, and osteoporosis; and various counseling services, including for breastfeeding, sexually-transmitted diseases, smoking, obesity, healthy dieting, cancer, and so forth. *See* U.S. Preventive Services Task Force, USPSTF A and B Recommendations, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last visited Nov. 19, 2013) (Ex. A); *see also* 75 Fed. Reg. 41726, 41740 (2010).

[8] For ease of reading, references to "HHS" in this Complaint refer to all Defendants, unless context indicates otherwise.

47. The interim final rule was enacted without prior notice of rulemaking or opportunity for public comment, because Defendants determined for themselves that "it would be impracticable and contrary to the public interest to delay putting the provisions . . . in place until a full public notice and comment process was completed." 75 Fed. Reg. at 41730.

48. Although Defendants suggested in the Interim Final Rule that they would solicit public comments after implementation, they stressed that "provisions of the Affordable Care Act protect significant rights" and therefore it was expedient that "participants, beneficiaries, insureds, plan sponsors, and issuers have certainty about their rights and responsibilities." *Id*.

49. Defendants stated they would later "provide the public with an opportunity for comment, but without delaying the effective date of the regulations," demonstrating their intent to impose the regulations regardless of the legal flaws or general opposition that might be manifest in public comments. *Id*.

50. In addition to reiterating the Affordable Care Act's preventive services coverage requirements, the Interim Final Rule provided further guidance concerning the Act's restriction on cost sharing.

51. The Interim Final Rule makes clear that "cost sharing" refers to "out-of-pocket" expenses for plan participants and beneficiaries. 75 Fed. Reg. at 41730.

52. The Interim Final Rule acknowledges that, without cost sharing, expenses "previously paid out-of-pocket" would "now be covered by group health plans and issuers" and that those expenses would, in turn, result in "higher average premiums for all enrollees." *Id.*; *see also id*. at 41737 ("Such a transfer of costs could be expected to lead to an increase in premiums.")

53. In other words, the prohibition on cost-sharing was simply a way "to distribute the cost of preventive services more equitably across the broad insured population." 75 Fed. Reg. at 41730.

54. After the Interim Final Rule was issued, numerous commenters warned against the potential conscience implications of requiring religious individuals and organizations to include certain kinds of services—specifically contraception, sterilization, and abortion services—in their health care plans.

55. HHS directed a private health policy organization, the Institute of Medicine (IOM), to make recommendations regarding which drugs, procedures, and services should be considered in comprehensive guidelines for preventive care for women.

56. IOM was not tasked with making insurance coverage recommendations and explicitly excluded cost considerations and other considerations relevant to coverage recommendations from its determinations regarding effective preventive care for women.

57. In developing its guidelines, IOM invited a select number of groups to make presentations on the preventive care that should be mandated by all health plans. These were the Guttmacher Institute, the American Congress of Obstetricians and Gynecologists (ACOG), John Santelli, the National Women's Law Center, National Women's Health Network, Planned Parenthood Federation of America, and Sara Rosenbaum.

58. No religious groups or other groups that opposed government-mandated coverage of contraception, sterilization, abortion, and related education and counseling were among the invited presenters.

59. On July 19, 2011, the IOM published its preventive care guidelines for women, including a recommendation that preventive services include all "Food and Drug Administration

approved contraceptive methods [and] sterilization procedures." Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*, at 102-10 and Recommendation 5.5 (2011).

60. FDA-approved contraceptive methods include birth-control pills; prescription contraceptive devices such as IUDs; Plan B (also known as the "morning-after pill"); ulipristal (also known as "ella" or the "week-after pill"); and other drugs, devices, and procedures.

61. Some of these drugs and devices—including the "emergency contraceptives" Plan B and ella and certain IUDs—are known abortifacients, in that they can cause the death of an embryo by preventing it from implanting in the wall of the uterus.

62. Indeed, the FDA's own Birth Control guide states that both Plan B and ella can work by "preventing attachment (implantation) to the womb (uterus)."[9]

63. On August 1, 2011, thirteen days after IOM issued its recommendations, HRSA issued guidelines adopting them in full.[10]

The "Religious Employers" Exemption

64. That same day, HHS promulgated an additional Interim Final Rule. 76 Fed. Reg. 46621 (published Aug. 3, 2011).

65. This Second Interim Final Rule granted HRSA "*discretion* to exempt certain religious employers from the Guidelines where contraceptive services are concerned." 76 Fed. Reg. 46621, 46623 (emphasis added). The term "religious employer" was restrictively defined as one that (1) has as its purpose the "inculcation of religious values"; (2) "primarily employs persons who share the religious tenets of the organization"; (3) "serves primarily persons who share the

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[9] FDA, Birth Control: Medicines to Help You, http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm (last visited Nov. 19, 2013) (Ex. B).

[10] HRSA, Women's Preventive Services Guidelines, http://www.hrsa.gov/womensguidelines (last visited Nov. 19, 2013) (Ex. C).

religious tenets of the organization"; and (4) "is a nonprofit organization as described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended." 76 Fed. Reg. at 46626.

66. The fourth of these requirements refers to "churches, their integrated auxiliaries, and conventions or associations of churches" and the "exclusively religious activities of any religious order." 26 U.S.C.A. § 6033.

67. Thus, the "religious employers" exemption was severely limited to formal churches, their integrated auxiliaries, and religious orders whose purpose is to inculcate faith and that hire and serve primarily people of their own faith tradition.

68. HRSA exercised its discretion to grant an exemption for religious employers via a footnote on its website listing the Women's Preventive Services Guidelines. The footnote states that "guidelines concerning contraceptive methods and counseling described above do not apply to women who are participants or beneficiaries in group health plans sponsored by religious employers." [11]

69. Although religious organizations like Belmont Abbey College share the same religious beliefs and concerns as objecting churches, their integrated auxiliaries, and objecting religious orders—including the order of Benedictine monks that sponsors Belmont Abbey College—HHS deliberately ignored the regulation's impact on their religious liberty, stating that the exemption sought only "to provide for a religious accommodation that respects the unique relationship between a house of worship and its employees in ministerial positions." 76 Fed. Reg. at 46623.

70. Thus, thousands of religious organizations that cannot comply with the mandate for religious reasons were excluded from the "religious employers" exemption.

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[11] HRSA, Women's Preventive Services Guidelines, http://www.hrsa.gov/womensguidelines.

71. Like the original Interim Final Rule, the Second Interim Final Rule was made effective immediately, without prior notice or opportunity for public comment.

72. Defendants acknowledged that "while a general notice of proposed rulemaking and an opportunity for public comment is generally required before promulgation of regulations," they had "good cause" to conclude that public comment was "impracticable, unnecessary, or contrary to the public interest" in this instance. 76 Fed. Reg. at 46624.

73. Upon information and belief, after the Second Interim Final Rule was put into effect, over 100,000 comments were submitted opposing the narrow scope of the "religious employers" exemption and protesting the contraception mandate's gross infringement on the rights of religious individuals and organizations.

74. HHS did not take into account the concerns of religious organizations in the comments submitted before the Second Interim Rule was issued.

75. Instead the Second Interim Rule was unresponsive to the concerns, including claims of statutory and constitutional conscience rights, stated in the comments submitted by religious organizations.

The Safe Harbor

76. The public outcry for a broader religious employer exemption continued for many months and, on January 20, 2013, HHS issued a press release acknowledging "the important concerns some have raised about religious liberty" and stating that religious objectors would be "provided an additional year . . . to comply with the new law."[12]

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[12] Press Release, A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius (Jan. 20, 2012), http://www.hhs.gov/news/press/2012pres/01/20120120a.html (Ex. D).

77. On February 10, 2012, HHS formally announced a "safe harbor" for non-exempt nonprofit religious organizations that objected to covering free contraceptive and abortifacient services. HHS Center for Consumer Information and Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (Feb. 10, 2012); *see also* HHS Center for Consumer Information and Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (Aug. 15, 2012) (changing the safe harbor eligibility criteria).

78. Under the safe harbor, HHS agreed it would not take any enforcement action against an eligible organization during the safe harbor, which would remain in effect until the first plan year beginning on or after August 1, 2013. HHS later extended the safe harbor to the first plan year beginning on or after January 1, 2014. HHS Center for Consumer Information and Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (June 28, 2013).

79. HHS also indicated it would develop and propose changes to the regulations to accommodate the objections of non-exempt, nonprofit religious organizations following August 1, 2013.

80. Despite the safe harbor and HHS's accompanying promises, on February 15, 2012, HHS published a final rule "finaliz[ing], without change," the contraception and abortifacient mandate and narrow religious employers exemption. 77 Fed. Reg. 8725-01 (published Feb. 15, 2012).

The Advance Notice of Proposed Rulemaking

81. On March 21, 2012, HHS issued an Advance Notice of Proposed Rulemaking (ANPRM), presenting "questions and ideas" to "help shape" a discussion of how to "maintain

the provision of contraceptive coverage without cost sharing," while accommodating the religious beliefs of non-exempt religious organizations. 77 Fed. Reg. 16501, 16503 (2012).

82. The ANPRM conceded that forcing religious organizations to "contract, *arrange*, or pay for" the objectionable contraceptive and abortifacient servicers would infringe their "religious liberty interests." *Id.* (emphasis added).

83. In vague terms, the ANPRM proposed that the "health insurance issuers" for objecting religious employers could be required to "assume the responsibility for the provision of contraceptive coverage without cost sharing." *Id.*

84. For self-insured plans, the ANPRM suggested that third party plan administrators "assume this responsibility." *Id.*

85. For the first time, and contrary to the earlier definition of "cost sharing," Defendants suggested in the ANPRM that insurers and third party administrators could be prohibited from passing along their costs to the objecting religious organizations via increased premiums. *See id.*

86. "[A]pproximately 200,000 comments" were submitted in response to the ANPRM. 78 Fed. Reg. 8456, 8459 (published February 6, 2013). Many of these comments reiterated previous comments that the ANPRM's proposals would not resolve conscientious objections, because the objecting religious organizations, by providing a health care plan in the first instance, would still be coerced to arrange for and facilitate access to religiously-objectionable drugs and services.

The Notice of Proposed Rulemaking

87. On February 1, 2013, HHS issued a Notice of Proposed Rulemaking (NPRM) purportedly addressing the comments submitted in response to the ANPRM. 78 Fed. Reg. 8456.

88. The NPRM proposed two changes to the then-existing regulations. 78 Fed. Reg. 8456, 8458-59.

89. First, it proposed revising the religious employers exemption by eliminating the requirements that religious employers have the purpose of inculcating religious values and primarily employ and serve only persons of their same faith. 78 Fed. Reg. at 8461

90. Under this proposal a "religious employer" would be one "that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or [](iii) of the Internal Revenue Code." 78 Fed. Reg. at 8474.

91. HHS emphasized, however, that this proposal "would not expand the universe of employer plans that would qualify for the exemption beyond that which was intended in the 2012 final rules." 78 Fed. Reg. at 8461.

92. In other words, religious organizations like Belmont Abbey College that are not formal churches would continue to be excluded from the exemption.

93. Second, the NPRM reiterated HHS's intention to "accommodate" non-exempt, nonprofit religious organizations by making them "designate" their insurers to provide plan participants and beneficiaries with free access to contraceptive and abortifacient drugs and services.

94. The proposed "accommodation" did not resolve the concerns of religious organizations like Belmont Abbey College because it continued to force them to deliberately provide health insurance and take actions that would trigger access to religiously-objectionable drugs and related education and counseling.

95. In issuing the NPRM, HHS requested comments from the public by April 8, 2013. 78 Fed. Reg. at 8457.

96. "[O]ver 400,000 comments" were submitted in response to the NPRM, 78 Fed. Reg. 39870, 39871 (published July 2, 2013), with religious organizations again overwhelmingly decrying the proposed accommodation as a gross violation of their religious liberty because it

would conscript their health care plans as the main cog in the government's scheme for expanding access to contraceptive and abortifacient services.

97. Belmont Abbey College submitted comments on the NPRM, stating essentially the same objections stated in this complaint.

98. On April 8, 2013, the same day the notice-and-comment period ended, Defendant Secretary Sebelius answered questions about the contraceptive and abortifacient services requirement in a presentation at Harvard University.

99. In her remarks, Secretary Sebelius stated:

> We have just completed the open comment period for the so-called accommodation, and by August 1st of this year, every employer will be covered by the law with one exception. Churches and church dioceses as employers are exempted from this benefit. But Catholic hospitals, Catholic universities, other religious entities *will be providing coverage* to their employees starting August 1st. . . . [A]s of August 1st, 2013, every employee who doesn't work directly for a church or a diocese *will be included* in the benefit package.[13]

100. It is clear from the timing of these remarks that Defendants gave no consideration to the comments submitted in response to the NPRM's proposed "accommodation."

<u>The Final Mandate</u>

101. On June 28, 2013, Defendants issued a final rule (the "Final Mandate"), which ignores the objections repeatedly raised by religious organizations and continues to co-opt objecting religious employers into the government's scheme of expanding free access to contraceptive and abortifacient services. 78 Fed. Reg. 39870.

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[13] The Forum at Harvard School of Public Health, A Conversation with Kathleen Sebelius, U.S. Secretary of Health and Human Services, Apr. 8, 2013, http://theforum.sph.harvard.edu/events/conversation-kathleen-sebelius (last visited Nov. 19, 2013) (from 51:20 to 53:56) (emphases added) (Ex. E). A permanent link to the relevant section of Sec. Sebelius' remarks is available here: http://www.youtube.com/watch?v=py6aSwQl-2g&feature=youtu.be (last visited Nov. 19, 2013).

102. Under the Final Mandate, the discretionary “religious employers” exemption, which is still implemented via footnote on the HRSA website, Ex. C, remains limited to formal churches and religious orders “organized and operate[d]” as nonprofit entities and “referred to in section 6033(a)(3)(A)(i) or (iii) of the [Internal Revenue] Code.” 78 Fed. Reg. at 39874.

103. All other religious organizations, including Belmont Abbey College, are excluded from the exemption.

104. The Final Mandate creates a separate “accommodation” for certain non-exempt religious organizations. 78 Fed. Reg. at 39874.

105. An organization is eligible for the accommodation if it (1) “[o]pposes providing coverage for some or all of the contraceptive services required”; (2) “is organized and operates as a nonprofit entity”; (3) “holds itself out as a religious organization”; and (4) “self-certifies that it satisfies the first three criteria.” 78 Fed. Reg. at 39874.

106. The self-certification must be executed “prior to the beginning of the first plan year to which an accommodation is to apply.” 78 Fed. Reg. at 39875.

107. The Final Rule extends the current safe harbor through the end of 2013. 78 Fed. Reg. at 39889; *see also* HHS Center for Consumer Information and Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (June 28, 2013) (extending the safe harbor to the first plan year that begins on or after January 1, 2014).

108. Thus, an eligible organization would need to execute the self-certification prior to its first plan year that begins on or after January 1, 2014, and deliver it to the organization’s insurer or, if the organization has a self-insured plan, to the plan’s third party administrator. 78 Fed. Reg. at 39875.

109. By the terms of the accommodation, Belmont Abbey College will be required to execute the self-certification and deliver it to its insurer before December 1, 2014.

110. By delivering its self-certification to its insurer, Belmont Abbey College would trigger the insurer's obligation to make "separate payments for contraceptive services directly for plan participants and beneficiaries." 78 Fed. Reg. at 39875-76.

111. Belmont Abbey College would have to identify its employees to the insurer for the distinct purpose of enabling the government's scheme to facilitate free access to contraceptive and abortifacient services.

112. The insurer's obligation to make direct payments for contraceptive and abortion services would continue only "for so long as the participant or beneficiary remains enrolled in the plan." 78 Fed. Reg. at 39876.

113. Thus Belmont Abbey College would have to coordinate with its insurer regarding when it was adding or removing employees and beneficiaries from its healthcare plan and, as a result, from the contraceptive, sterilization, and abortifacient services payment scheme.

114. Insurers would be required to notify plan participants and beneficiaries of the contraceptive payment benefit "contemporaneous with (to the extent possible) but separate from any application materials distributed in connection with enrollment" in a group health plan. 78 Fed. Reg. at 39876.

115. This would also require Belmont Abbey College to coordinate the notices with its insurer.

116. The insurer would be required to provide the contraceptive benefits "in a manner consistent" with the provision of other covered services. 78 Fed. Reg. at 39876-77.

117. Thus, any payment or coverage disputes presumably would be resolved under the terms of Belmont Abbey College's existing plan documents.

118. Thus, even under the accommodation, Belmont Abbey College and every other non-exempt objecting religious organization would continue to play a central role in facilitating free access to contraceptive, sterilization, and abortifacient services.

119. Under the accommodation, issuers "may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), *or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly*, on the eligible organization." 78 Fed. Reg. at 39896 (emphasis added).

120. For all other preventive services, including non-contraceptive preventive services for women, only cost-sharing (*i.e.*, out-of-pocket expense) is prohibited. There is no restriction on passing along costs via premiums or other charges.

121. Defendants state that they "continue to believe, and have evidence to support," that providing payments for contraceptive and abortifacient services will be "cost neutral for issuers," because "[s]everal studies have estimated that the costs of providing contraceptive coverage are balanced by cost savings from lower pregnancy-related costs and from improvements in women's health." 78 Fed. Reg. at 39877.

122. On information and belief, the studies Defendants rely upon to support this claim are severely flawed.

123. Nevertheless, even if the payments were—over time—to become cost neutral, it is undisputed that there will be up-front costs for making the payments. *See, e.g.,* 78 Fed. Reg. at 39877-78 (addressing ways insurers can cover up-front costs).

124. Moreover, if cost savings arise that make insuring an employer's employees cheaper, the savings would have to be passed on to employers through reduced premiums, not retained by insurance issuers.

125. HHS suggests that, to maintain cost neutrality, issuers may simply ignore this fact and "set the premium for an eligible organization's large group policy as if no payments for contraceptive services had been provided to plan participants." 78 Fed. Reg. at 39877.

126. This encourages issuers to artificially inflate the eligible organization's premiums.

127. Under this methodology—even assuming its legality—the eligible organization would still bear the cost of the required payments for contraceptive, sterilization, and abortifacient services in violation of its conscience, as if the accommodation had never been made.

128. Defendants have suggested that "[a]nother option" would be to "treat the cost of payments for contraceptive services . . . as an administrative cost that is spread across the issuer's entire risk pool, excluding plans established or maintained by eligible organizations." 78 Fed. Reg. at 39878.

129. There is no legal authority for forcing third parties to pay for services provided to eligible organizations under the accommodation.

130. Furthermore, under the Affordable Care Act, Defendants lack authority in the first place to coerce insurers to directly purchase contraceptive, sterilization, and abortifacient services for an eligible organization's plan participants and beneficiaries.

131. Thus, the accommodation fails to protect objecting religious organizations for lack of statutory authority.

132. Currently, Belmont Abbey College is insured through Blue Cross Blue Shield of North Carolina. Because Belmont Abbey College would be required to identify and designate an

insurer willing to administer the contraceptive and abortifacient services, Belmont Abbey College's religious beliefs preclude it from complying with the accommodation.

133. For all these reasons, the accommodation does nothing to relieve non-exempt religious organizations with insured plans—such as Belmont Abbey College—from being co-opted as the central cog in the government's scheme to expand access to free contraceptive and abortifacient services.

134. The Final Rule sets forth complex means through which a third party administrator may seek to recover its costs incurred in making payments for contraceptive and abortifacient services.

135. The third party administrator must identify an issuer who participates in the federal exchanges established under the Affordable Care Act and who would be willing to make payments on behalf of the third party administrator.

136. Cooperating issuers would then be authorized to obtain refunds from the user fees they have paid to participate in the federal exchange as a means of being reimbursed for making payments for contraceptive and abortifacient services on behalf of the third party administrator.

137. Issuers would be required to pay a portion of the refund back to the third party administrator to compensate it for any administrative expenses it has incurred.

138. These extreme machinations, ostensibly employed only to shift the *cost* of the Final Mandate, are severely flawed.

139. There is no way to ensure that the cost of administering the contraceptive and abortifacient services would not be passed on to religious organizations through the third party administrator's fees.

140. Moreover, taking the user fees intended for funding the federal exchanges and using them to provide contraceptive and abortifacient services to employees not participating in the federal exchanges would violate the statute authorizing the user fees. *See* 78 Fed. Reg. 15410, 15412 (published March 11, 2013); 31 U.S.C. § 9701.

141. In sum, for both insured organizations like Belmont Abbey College and self-insured organizations, the accommodation is nothing more than a shell game that attempts to disguise the religious organization's role as the central cog in the government's scheme for expanding access to contraceptive and abortifacient services.

142. Despite the accommodation's convoluted machinations, a religious organization's decision to offer health insurance and its self-certification continue to serve as the sole triggers for creating access to free contraceptive and abortifacient services.

143. Belmont Abbey College cannot participate in or facilitate the government's scheme in this manner without violating its religious convictions.

Belmont Abbey College's Health Care Plan and Its Religious Objections

144. The plan year for Belmont Abbey College's employee healthcare plan begins on December 1 of each year.

145. Belmont Abbey College's employee health care plan is an insured plan issued by Blue Cross Blue Shield of North Carolina.

146. Thus, beginning on or about December 1, 2014, Belmont Abbey College faces the choice of either including free coverage for contraceptive and abortifacient services in its employee health plan or else forcing its insurer to provide the exact same services.

147. Belmont Abbey College has no objection to including, and already does include, free coverage for women's preventive services such as mammograms. It also has no conscientious

objection to providing access to drugs typically used for contraception when they are instead used for purely medical reasons unrelated to birth control, such as treating ovarian cysts.

148. However, Belmont Abbey College's religious convictions forbid it from including free coverage for abortifacient, sterilization, or contraceptive services in any of its healthcare plans.

149. Belmont Abbey College's religious convictions equally forbid it from hiring or designating its insurer to provide free access to abortifacient, sterilization, or contraceptive services.

150. From Belmont Abbey College's perspective, forcing its insurance issuer to provide free access to abortifacient, sterilization, or contraceptive services is no different than directly providing that access.

151. Belmont Abbey College's religious convictions forbid it from participating in any way in the government's scheme to promote and provide free access to abortifacient, sterilization, or contraceptive services through Belmont Abbey College's health care plans.

152. Belmont Abbey College is not eligible for the religious employers exemption because it is not an organization "described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended." 76 Fed. Reg. at 46626.

153. Belmont Abbey College's current employee health insurance plan has changed significantly after March 23, 2010 and has never included the statements regarding grandfathered status required under federal law.

154. Belmont Abbey's employee healthcare plan does not meet the definition of a "grandfathered" plan. *See* 45 C.F.R. § 147.140(a)(1)(i); 26 C.F.R. § 54.9815-1251T(a)(1)(i); 29 C.F.R. § 2590.715-1251(a)(1)(i).

155. Because Belmont Abbey College is unable to comply with the Final Mandate because of its religious beliefs, and because it is unable to force its insurer to carry out the Final Mandate by submitting a self-certification, it faces crippling fines of $100 each day, for "each individual to whom such failure relates." 26 U.S.C. § 4980D(b)(1).

156. Dropping its insurance plans would unfairly and severely burden Belmont Abbey College's employees, and would place Belmont Abbey College at a severe competitive disadvantage in its efforts to recruit and retain employees.

157. Belmont Abbey College would also face fines of $2000 per year for each of its employees for dropping its insurance plans.

158. Although the government has recently announced that it will postpone implementing the annual fine of $2000 per employee for organizations that drop their insurance altogether, the postponement is only for one year, until 2015. This postponement does not delay the crippling daily fines under 26 U.S.C. § 4980D.

159. Belmont Abbey College's Catholic faith compels it to promote the spiritual and physical well-being of its employees by providing them with generous health services.

160. The Final Mandate forces Belmont Abbey College to violate its religious beliefs or incur substantial fines for either excluding objectionable coverage without forcing its insurance issuer to provide the same coverage, or terminating its employee health insurance coverage altogether.

161. The Final Mandate forces Belmont Abbey College to deliberately provide health insurance that would facilitate free access to abortifacient, sterilization, or contraceptive services regardless of the ability of insured persons to obtain these drugs and services from other sources.

162. The Final Mandate forces Belmont Abbey College to facilitate government-dictated education and counseling concerning abortion, sterilization, and contraceptive use that are incompatible with its religious beliefs and teachings.

163. Facilitating this government-dictated speech is incompatible and irreconcilable with the express speech and messages concerning the sanctity of life and sexuality that Belmont Abbey College seeks to convey.

The Lack of a Compelling Government Interest

164. The government lacks any compelling interest in coercing Belmont Abbey College to facilitate access to abortifacient, sterilization, or contraceptive services.

165. The required abortifacient, sterilization, or contraceptive drugs, devices, and related services are already widely available at non-prohibitive costs.

166. There are multiple ways in which the government could provide access without co-opting religious employers and their insurance plans in violation of their religious beliefs.

167. For example, it could pay for the objectionable services through its existing network of family planning services funded under Title X, through direct government payments, or through tax deductions, refunds, or credits.

168. The government could also simply exempt all religious organizations, just as it has already exempted nonprofit religious employers referred to in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code.

169. HHS claims that its "religious employers" exemption does not undermine its compelling interest in making contraceptive and abortifacient services available for free to women because "houses of worship and their integrated auxiliaries that object to contraceptive coverage on religious grounds are more likely than other employers to employ people who are of

the same faith and/or adhere to the same objection, and who would therefore be less likely than other people to use contraceptive services even if such services were covered under their plan." 78 Fed. Reg. at 39887.

170. Belmont Abbey College's employees commit to further its mission of being a distinctively Catholic and Benedictine institution, including its mission of communicating Catholic beliefs concerning the sanctity of life and sexuality.

171. Because of Belmont Abbey College's religious obligation under *Ex Corde Ecclesiae* to proclaim Catholic teaching regarding the sanctity of life and sexuality, many of the students and employees that have chosen to join the Belmont Abbey College community are just as likely as employees of exempt organizations to adhere to the same values, and thus are less likely than other people to use the objectionable drugs, devices, and services.

172. In one form or another, the government also provides exemptions for grandfathered plans, 42 U.S.C. § 18011; 75 Fed. Reg. 41726, 41731 (2010), small employers with fewer than 50 employees, 26 U.S.C. § 4980H(c)(2)(A), and certain religious denominations, 26 U.S.C. § 5000A(d)(2)(a)(i) and (ii) (individual mandate does not apply to members of "recognized religious sect or division" that conscientiously objects to acceptance of public or private insurance funds); 26 U.S.C. § 5000A(d)(2)(b)(ii) (individual mandate does not apply to members of "health care sharing ministry" that meets certain criteria).

173. These broad exemptions further demonstrate that the government has no compelling interest in refusing to include religious organizations like Belmont Abbey College within its religious employers exemption.

174. Employers who follow HHS guidelines may continue to use grandfathered plans indefinitely.

175. Indeed, HHS has predicted that a majority of large employers, employing more than 50 million Americans, will continue to use grandfathered plans through at least 2014, and that a third of medium-sized employers with between 50 and 100 employees may do likewise. 75 Fed. Reg. 34538 (published June 17, 2010).[14]

176. According to the United States census, more than 20 million individuals are employed by firms with fewer than 20 employees.[15]

177. It is reasonable to presume that millions more are employed by firms with between 20 and 50 employees.

178. The government's recent decision to postpone the employer mandate—i.e., the annual fine of $2000 per employee for not offering any insurance—also demonstrates that there is no compelling interest in coercing universal compliance with the Final Mandate concerning contraceptive and abortifacient services, since employers can now simply drop their insurance without any penalty, at least for one additional year.

179. These broad exemptions also demonstrate that the Final Mandate is not a generally applicable law entitled to judicial deference, but rather is constitutionally flawed.

180. The government's willingness to exempt various secular organizations and postpone the employer mandate, while adamantly refusing to provide anything but the narrowest of exemptions for religious organizations also shows that the Final Mandate is not neutral, but

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[14] *See also* Centers for Medicare & Medicaid Services, Amendment to Regulation on "Grandfathered" Health Plans under the Affordable Care Act, https://www.cms.gov/CCIIO/Resources/Files/factsheet_grandfather_amendment.html (noting that amendment to regulations "will result in a small increase in the number of plans retaining their grandfathered status relative to the estimates made in the grandfathering regulation") (last visited Nov. 19, 2013) (Ex. F).

[15] U.S. Census Bureau, Statistics About Business Size, http://www.census.gov/econ/smallbus.html (last visited Nov. 19, 2013) (Ex. G).

rather discriminates against religious organizations because of their religious commitment to promoting the sanctity of life.

181. Indeed, the Final Mandate was promulgated by government officials, and supported by non-governmental organizations, who strongly oppose Belmont Abbey College's religious teachings and beliefs regarding marriage and family.

182. Defendant Sebelius, for example, has long been a staunch supporter of abortion rights and a vocal critic of religious teachings and beliefs regarding abortion and contraception.

183. On October 5, 2011, six days after the comment period for the original interim final rule ended, Defendant Sebelius gave a speech at a fundraiser for NARAL Pro-Choice America. She told the assembled crowd that "we are in a war."[16]

184. She further criticized individuals and entities whose beliefs differed from those held by her and the others at the fundraiser, stating: "Wouldn't you think that people who want to reduce the number of abortions would champion the cause of widely available, widely affordable contraceptive services? Not so much."

185. On July 16, 2013, Secretary Sebelius further compared opponents of the Affordable Care Act generally to people who opposed civil rights legislation in the 1960s, stating that upholding the Act requires the same action as was shown "in the fight against lynching and the fight for desegregation."[17]

186. Consequently, on information and belief, Belmont Abbey College alleges that the purpose of the Final Mandate, including the restrictively narrow scope of the religious employers

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[16] William McGurn, *The Church of Kathleen Sebelius*, Wall St. J., Dec. 13, 2011, *available at* http://online.wsj.com/news/articles/SB10001424052970203518404577094631979925326 (Ex. H).

[17] *See* Kathleen Sebelius, Remarks at the 104th NAACP Annual Conference, July 16, 2013, http://www.hhs.gov/secretary/about/speeches/sp20130716.html (Ex. I).

exemption, is to discriminate against religious organizations that oppose contraception and abortion.

CLAIMS

COUNT I

Violation of the Religious Freedom Restoration Act
Substantial Burden

187. Belmont Abbey College incorporates by reference all preceding paragraphs.

188. Belmont Abbey College's sincerely held religious beliefs prohibit it from deliberately providing health insurance that would facilitate access to contraception, sterilization, abortion, or related education and counseling. Belmont Abbey College's compliance with these beliefs is a religious exercise.

189. The Final Mandate creates government-imposed coercive pressure on Belmont Abbey College to change or violate its religious beliefs.

190. The Final Mandate chills the Belmont Abbey College's religious exercise.

191. The Final Mandate exposes Belmont Abbey College to substantial fines for its religious exercise.

192. The Final Mandate exposes Belmont Abbey College to substantial competitive disadvantages, in that it will no longer be permitted to offer health insurance.

193. The Final Mandate imposes a substantial burden on Belmont Abbey College's religious exercise.

194. The Final Mandate furthers no compelling governmental interest.

195. The Final Mandate is not narrowly tailored to any compelling governmental interest.

196. The Final Mandate is not the least restrictive means of furthering Defendants' stated interests.

197. The Final Mandate and Defendants' threatened enforcement of the Final Mandate violate Belmont Abbey College's rights secured to it by the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb *et seq.*

198. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT II

Violation of the First Amendment to the United States Constitution
Free Exercise Clause
Burden

199. Belmont Abbey College incorporates by reference all preceding paragraphs.

200. Belmont Abbey College's sincerely held religious beliefs prohibit it from deliberately providing health insurance that would facilitate access to contraception, sterilization, abortion, or related education and counseling. Belmont Abbey College's compliance with these beliefs is a religious exercise.

201. Neither the Affordable Care Act nor the Final Mandate is neutral.

202. Neither the Affordable Care Act nor the Final Mandate is generally applicable.

203. Defendants have created categorical exemptions and individualized exemptions to the Final Mandate.

204. The Final Mandate furthers no compelling governmental interest.

205. The Final Mandate is not the least restrictive means of furthering Defendants' stated interests.

206. The Final Mandate creates government-imposed coercive pressure on Belmont Abbey College to change or violate its religious beliefs.

207. The Final Mandate chills Belmont Abbey College's religious exercise.

208. The Final Mandate exposes Belmont Abbey College to substantial fines for its religious exercise.

209. The Final Mandate exposes Belmont Abbey College to substantial competitive disadvantages, in that it will no longer be permitted to offer health insurance.

210. The Final Mandate imposes a burden on Belmont Abbey College's religious exercise.

211. The Final Mandate is not narrowly tailored to any compelling governmental interest.

212. The Final Mandate and Defendants' threatened enforcement of the Final Mandate violate Belmont Abbey College's rights secured to it by the Free Exercise Clause of the First Amendment of the United States Constitution.

213. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT III

Violation of the First Amendment to the United States Constitution
Free Exercise Clause
Intentional Discrimination

214. Belmont Abbey College incorporates by reference all preceding paragraphs.

215. Belmont Abbey College's sincerely held religious beliefs prohibit it from deliberately providing health insurance that would facilitate access to contraception, sterilization, abortion, or related education and counseling. Belmont Abbey College's compliance with these beliefs is a religious exercise.

216. Despite being informed in detail of these beliefs beforehand, Defendants designed the Final Mandate and the religious employer exemption to the Final Mandate to target religious organizations like Belmont Abbey College because of their religious beliefs.

217. Defendants promulgated both the Final Mandate and its religious employer exemption in order to suppress the religious exercise of Belmont Abbey College and others.

218. The Final Mandate and Defendants' threatened enforcement of the Final Mandate thus violate Belmont Abbey College's rights secured to it by the Free Exercise Clause of the First Amendment of the United States Constitution.

219. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT IV

Violation of the First Amendment to the United States Constitution
Free Exercise and Establishment Clauses
Discrimination Among Religions and Religious Institutions

220. Belmont Abbey College incorporates by reference all preceding paragraphs.

221. The Free Exercise Clause and Establishment Clause of the First Amendment mandate the equal treatment of all religious faiths and institutions without discrimination or preference.

222. This mandate of equal treatment protects organizations as well as individuals.

223. The Final Mandate's narrow exemption for "religious employers" but not others discriminates among religions and religious institutions on the basis of religious views or religious status.

224. The Final Mandate and Defendants' threatened enforcement of the Final Mandate thus violate Belmont Abbey College's rights secured to it by the First Amendment of the United States Constitution.

225. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT V

Violation of the First Amendment to the United States Constitution
Selective Burden (*Larson* v. *Valente*)

226. Belmont Abbey College incorporates by reference all preceding paragraphs.

227. By design, defendants imposed the Final Mandate on some religious organizations but not on others, resulting in a selective burden on Belmont Abbey College.

228. The Final Mandate and Defendants' threatened enforcement of the Final Mandate therefore violate Belmont Abbey College's rights secured to it by the First Amendment of the United States Constitution.

229. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

230. The Final Mandate vests HRSA with unbridled discretion in deciding whether to allow exemptions to some, all, or no organizations meeting the definition of "religious employers."

COUNT VI

Interference in Matters of Internal Religious Governance
Free Exercise Clause and Establishment Clause

231. Belmont Abbey College incorporates by reference all preceding paragraphs.

232. The Free Exercise Clause and the Establishment Clause protect the freedom of religious organizations to decide for themselves, free from state interference, matters of internal governance as well as those of faith and doctrine.

233. Under these Clauses, the Government may not interfere with a religious organization's internal decisions concerning the organization's religious structure, leadership, or doctrine.

234. Under these Clauses, the Government may not interfere with a religious organization's internal decision if that interference would affect the faith and mission of the organization itself.

235. Belmont Abbey College has made an internal decision, dictated by its Christian faith, that any health plans it makes available to its employees may not subsidize, provide, or facilitate access to abortifacient, sterilization, or contraceptive drugs, devices, or related services.

236. The Final Mandate interferes with Belmont Abbey College's internal decisions concerning its structure and mission by requiring it to subsidize, provide, and facilitate practices that directly conflict with its Christian beliefs

237. The Final Mandate's interference with Belmont Abbey College's internal decisions affects its faith and mission by requiring it to subsidize, provide, and facilitate practices that directly conflict with its religious beliefs.

238. Because the Final Mandate interferes with Belmont Abbey College's internal decision making in a manner that affects its faith and mission, it violates the Establishment Clause and Free Exercise Clause of the First Amendment.

Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT VII

Religious Discrimination
Violation of the First and Fifth Amendments to the United States Constitution
Establishment Clause and Due Process

239. Belmont Abbey College incorporates by reference all preceding paragraphs.

240. By design, defendants imposed the Final Mandate on some religious organizations but not on others, resulting in discrimination among religious objectors.

241. Religious liberty is a fundamental right.

242. The "religious employer" exemption protects many religious objectors, but not Belmont Abbey College.

243. The "accommodation" provides no meaningful protection for Belmont Abbey College.

244. The Final Mandate and Defendants' threatened enforcement of the Final Mandate therefore violate Belmont Abbey College's rights secured to it by the Establishment Clause of

the First Amendment and the Due Process Clause of the Fifth Amendment to the United States Constitution.

245. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT VIII

Violation of the Fifth Amendment to the United States Constitution
Due Process and Equal Protection

246. Belmont Abbey College incorporates by reference all preceding paragraphs.

247. The Due Process Clause of the Fifth Amendment mandates the equal treatment of all religious faiths and institutions without discrimination or preference.

248. This mandate of equal treatment protects organizations as well as individuals.

249. The Final Mandate's narrow exemption for "religious employers" but not others discriminates among religions on the basis of religious views or religious status.

250. The Final Mandate and Defendants' threatened enforcement of the Final Mandate thus violate Belmont Abbey College's rights secured to it by the Fifth Amendment of the United States Constitution.

251. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT IX

Violation of the First Amendment to the United States Constitution
Freedom of Speech
Compelled Speech and Compelled Silence

252. Belmont Abbey College incorporates by reference all preceding paragraphs.

253. Belmont Abbey College teaches that contraception, sterilization, and abortion violate its religious beliefs.

254. The Final Mandate would compel Belmont Abbey College to subsidize activities that Belmont Abbey College teaches are violations of Belmont Abbey College's religious beliefs.

255. The Final Mandate would compel Belmont Abbey College to provide education and counseling related to contraception, sterilization, and abortion.

256. Defendants' actions thus violate Belmont Abbey College's right to be free from compelled speech as secured to it by the First Amendment of the United States Constitution.

257. If Belmont Abbey College chose to use a third-party administrator, the Final Mandate also prevents Belmont Abbey College from speaking to that administrator about its religious beliefs and preference that the administrator not provide the services at issue.

258. The Final Mandate's speech restrictions are not narrowly tailored to a compelling governmental interest.

259. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT X

Violation of the First Amendment to the United States Constitution
Freedom of Speech
Expressive Association

260. Belmont Abbey College incorporates by reference all preceding paragraphs.

261. Belmont Abbey College teaches that contraception, sterilization, and abortion violate its religious beliefs.

262. The Final Mandate would compel Belmont Abbey College to facilitate activities that Belmont Abbey College teaches are violations of Belmont Abbey College's religious beliefs.

263. The Final Mandate would compel Belmont Abbey College to facilitate access to government-dictated education and counseling related to contraception, sterilization, and abortion.

264. Defendants' actions thus violate Belmont Abbey College's right of expressive association as secured to it by the First Amendment of the United States Constitution.

265. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT XI

Violation of the First Amendment to the United States Constitution
Free Exercise Clause and Freedom of Speech
Unbridled Discretion

266. Belmont Abbey College incorporates by reference all preceding paragraphs.

267. By stating that HRSA "may" grant an exemption to certain religious groups, the Final Mandate vests HRSA with unbridled discretion over which organizations can have its First Amendment interests accommodated.

268. Defendants have exercised unbridled discretion in a discriminatory manner by granting an exemption via footnote in a website for a narrowly defined group of "religious employers" but not for other religious organizations like Belmont Abbey College.

269. Defendants have further exercised unbridled discretion by indiscriminately waiving enforcement of some provisions of the Affordable Care Act while refusing to waive enforcement of the Final Mandate, despite its conflict with the free exercise of religion.

270. Defendants' actions therefore violate Belmont Abbey College's right not to be subjected to a system of unbridled discretion when engaging in speech or when engaging in religious exercise, as secured to it by the First Amendment of the United States Constitution.

271. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT XII

Violation of the Administrative Procedure Act
Lack of Good Cause and Improper Delegation

272. Belmont Abbey College incorporates by reference all preceding paragraphs.

273. The Affordable Care Act expressly delegates to HRSA, an agency within Defendant HHS, the authority to establish guidelines concerning the "preventive care" that a group health plan and health insurance issuer must provide.

274. Given this express delegation, Defendants were required to engage in formal notice-and-comment rulemaking in a manner prescribed by law before issuing the guidelines that group health plans and insurers must cover. Proposed regulations were required to be published in the Federal Register and interested persons were required to be given an opportunity to participate in the rulemaking through the submission of written data, views, or arguments.

275. Defendants promulgated the "preventive care" guidelines without engaging in formal notice-and-comment rulemaking in a manner prescribed by law. Defendants, instead, wholly delegated their responsibilities for issuing preventive care guidelines to a non-governmental entity, the IOM.

276. The IOM did not permit or provide for the broad public comment otherwise required under the APA concerning the guidelines that it would recommend. The dissent to the IOM report noted both that the IOM conducted its review in an unacceptably short time frame, and that the review process lacked transparency.

277. Within two weeks of the IOM issuing its guidelines, Defendant HHS issued a press release announcing that the IOM's guidelines were required under the Affordable Care Act.

278. Defendants have never explained why they failed to enact these "preventive care" guidelines through notice-and-comment rulemaking as required by the APA.

279. Defendants' stated reasons that public comments were unnecessary, impractical, and opposed to the public interest are false and insufficient, and do not constitute "good cause."

280. Without proper notice and opportunity for public comment, Defendants were unable to take into account the full implications of the regulations by completing a meaningful "consideration of the relevant matter presented."

281. Defendants did not consider or respond to the voluminous comments they received in opposition to the interim final rule or the NPRM.

282. Therefore, Defendants have taken agency action not in observance with procedures required by law, and Belmont Abbey College is entitled to relief pursuant to 5 U.S.C. § 706(2)(D).

283. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT XIII

Violation of the Administrative Procedure Act
Arbitrary and Capricious Action

284. Belmont Abbey College incorporates by reference all preceding paragraphs.

285. In promulgating the Final Mandate, Defendants failed to consider the constitutional and statutory implications of the Final Mandate on Belmont Abbey College and similar organizations.

286. Defendants' explanation for its decision not to exempt Belmont Abbey College and similar religious organizations from the Final Mandate runs counter to the evidence submitted by religious organizations during the comment period.

287. Defendant Secretary Sebelius, in remarks made at Harvard University on April 8, 2013, essentially conceded that Defendants completely disregarded the religious liberty concerns submitted by thousands of religious organizations and individuals.

288. Thus, Defendants' issuance of the interim final rule was arbitrary and capricious within the meaning of 5 U.S.C. § 706(2)(A) because the rules fail to consider the full extent of their implications and they do not take into consideration the evidence against them.

289. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT XIV

Violation of the Administrative Procedure Act
Agency Action Without Statutory Authority

290. Belmont Abbey College incorporates by reference all preceding paragraphs.

291. Defendant's authority to enact regulations under the Affordable Care Act is limited to the authority expressly granted them by Congress.

292. Defendants lack statutory authority to coerce insurance issuers and third party administrators to pay for contraceptive and abortifacient services for individuals with whom they have no contractual or fiduciary relationship.

293. Defendants lack statutory authority to prevent insurance issuers and third party administrators from passing on the costs of providing contraceptive and abortifacient services via higher premiums or other charges that are not "cost sharing."

294. Defendants lack statutory authority to allow user fees from the federal exchanges to be used to purchase contraceptive and abortifacient services for employees not participating in the exchanges.

295. Because the Final Mandate's "accommodation" for non-exempt, nonprofit religious organizations lacks legal authority, it is arbitrary and capricious and provides no legitimate protection of objecting organization's First Amendment rights.

296. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT XV

Violation of the Administrative Procedure Act
Agency Action Not in Accordance with Law
Weldon Amendment
Religious Freedom Restoration Act
First Amendment to the United States Constitution

297. Belmont Abbey College incorporates by reference all preceding paragraphs.

298. The Final Mandate is contrary to the provisions of the Weldon Amendment of the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009, Pub. L. 110-117, 123 Stat. 3034 (Dec. 16, 2009).[18]

299. The Weldon Amendment provides that "[n]one of the funds made available in this Act [making appropriations for Defendants Department of Labor and Health and Human Services] may be made available to a Federal agency or program . . . if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."

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[18] *Available at* http://www.hhs.gov/ocr/civilrights/understanding/ConscienceProtect/publaw111_117_123_stat_3034.pdf (Ex. J).

300. The Final Mandate requires issuers, including Belmont Abbey College, to deliberately provide health insurance that facilitates access to all Federal Drug Administration-approved contraceptives.

301. Some FDA-approved contraceptives cause abortions.

302. As set forth above, the Final Mandate violates RFRA and the First Amendment.

303. Under 5 U.S.C. § 706(2)(A), the Final Mandate is contrary to existing law, and is in violation of the APA.

304. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

COUNT XVI

Violation of the Administrative Procedure Act
Agency Action Not in Accordance with Law
Affordable Care Act

305. Belmont Abbey College incorporates by reference all preceding paragraphs.

306. The Final Mandate is contrary to the provisions of the Affordable Care Act.

307. Section 1303 of the Affordable Care Act states that "nothing in this title"—*i.e.*, title I of the Act, which includes the provision dealing with "preventive services"—"shall be construed to require a qualified health plan to provide coverage of [abortion] services . . . as part of its essential health benefits for any plan year."

308. Section 1303 further states that it is "the issuer" of a plan that "shall determine whether or not the plan provides coverage" of abortion services.

309. Under the Affordable Care Act, Defendants do not have the authority to decide whether a plan covers abortion; only the issuer does.

310. The Final Mandate requires group health plans, including Belmont Abbey College's, to provide coverage of all Federal Drug Administration-approved contraceptives.

311. Some FDA-approved contraceptives cause abortions.

312. Under 5 U.S.C. § 706(2)(A), the Final Mandate is contrary to existing law, and is in violation of the APA.

313. Absent injunctive and declaratory relief against the Final Mandate, Belmont Abbey College has been and will continue to be harmed.

PRAYER FOR RELIEF

Wherefore, Belmont Abbey College requests that the Court:

a. Declare that the Final Mandate and Defendants' enforcement of the Final Mandate against Belmont Abbey College violate the First Amendment of the United States Constitution;

b. Declare that the Final Mandate and Defendants' enforcement of the Final Mandate against Belmont Abbey College violate the Fifth Amendment of the United States Constitution;

c. Declare that the Final Mandate and Defendants' enforcement of the Final Mandate against Belmont Abbey College violate the Religious Freedom Restoration Act;

d. Declare that the Final Mandate was issued in violation of the Administrative Procedure Act;

e. Issue a permanent injunction prohibiting Defendants from enforcing the Final Mandate against Belmont Abbey College and other organizations that object on religious grounds to providing insurance coverage for contraceptives (including

abortifacient contraceptives), sterilization procedures, and related education and counseling;

f. Award Belmont Abbey College the costs of this action and reasonable attorney's fees; and

g. Award such other and further relief as it deems equitable and just.

Respectfully submitted this 20th day of November, 2013.

JURY DEMAND

Belmont Abbey College requests a trial by jury on all issues so triable.

s/ *Mark Rienzi*
Mark Rienzi, DC Bar No. 494336
Adèle Auxier Keim, DC Bar No. 989528
THE BECKET FUND FOR RELIGIOUS LIBERTY
3000 K St. NW, Ste. 220
Washington, DC 20007
(202) 955-0095 (tel.)
(202) 955-0090 (fax)

Attorneys for Plaintiff
Belmont Abbey College

VERIFICATION OF COMPLAINT ACCORDING TO 28 U.S.C. § 1746

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on Nov. 19, 2013 in Belmont, NC.

Dr. William Thierfelder
President, Belmont Abbey College

Exhibit A

U.S. Preventive Services Task Force

USPSTF Home Resource Links E-mail Updates

You Are Here: U.S. Preventive Services Task Force > Topic Index > USPSTF A and B Recommendations

USPSTF A and B Recommendations

The following is a list of preventive services that have a rating of A or B from the U.S. Preventive Services Task Force that are relevant for implementing the Affordable Care Act. The preventive services are listed alphabetically. For a list of preventive services by date of release of the current recommendation, go to http://www.uspreventiveservicestaskforce.org/uspstf/uspsrecsdate.htm.

For more information about the Affordable Care Act and preventive services, go to https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	February 2005
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006
Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
BRCA screening, counseling about	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes be referred for genetic counseling and evaluation for BRCA testing.	B	September 2005

Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydial infection screening: nonpregnant women	The USPSTF recommends screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk.	A	June 2007
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.	B	June 2007
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Dental caries prevention: preschool children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than age 6 months whose primary water source is deficient in fluoride.	B	April 2004
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 2009
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis,	B	December 2009

	effective treatment, and follow-up.		
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B	May 2005
Healthy diet counseling	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	January 2003
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who	B	January 2013

	do not have signs or symptoms of abuse.		
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	A	March 2008
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.	B	October 2008
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 2009
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A	April 2009
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011*

†The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm.
* Previous recommendation was an "A" or "B."

Current as of November 2013

Internet Citation:

USPSTF A and B Recommendations. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

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Exhibit B

Birth Control: Medicines To Help You

Introduction

If you do not want to get pregnant, there are many birth control options to choose from. No one product is best for everyone. The only sure way to avoid pregnancy and sexually transmitted infections (STIs or STDs) is not to have any sexual contact (abstinence). This guide lists FDA-approved products for birth control. Talk to your doctor, nurse, or pharmacist about the best method for you.

There are different kinds of medicines and devices for birth control:

Barrier Methods

Hormonal Methods

Emergency Contraception

Implanted Devices

Permanent Methods

Some things to think about when you choose birth control:

- Your health.
- How often you have sex.
- How many sexual partners you have.
- If you want to have children in the future.
- If you will need a prescription or if you can buy the method over-the-counter.
- The number of pregnancies expected per 100 women who use a method for one year. For comparison, about 85 out of 100 sexually active women who do not use any birth control can expect to become pregnant in a year.
- This booklet lists pregnancy rates of **typical use**. Typical use shows how effective the different methods are during actual use (including sometimes using a method in a way that is not correct or not consistent).
- For more information on the chance of getting pregnant while using a method, please see Trussell,J. (2011)."Contraceptive failure in the United States." Contraception 83(5):397-404.

Tell your doctor, nurse, or pharmacist if you:

- Smoke.
- Have liver disease.
- Have blood clots.
- Have family members who have had blood clots.
- Are taking any other medicines, like antibiotics.
- Are taking any herbal products, like St. John's Wort.

To avoid pregnancy:

- No matter which method you choose, it is important to follow all of the directions carefully. If you don't, you raise your chance of getting pregnant.
- The best way to avoid pregnancy and sexually transmitted infections (STIs) is to practice total abstinence (do not have any sexual contact).

BARRIER METHODS: Block sperm from reaching the egg

Male Condom

What is it?

- A thin film sheath placed over the erect penis.

How do I use it?

- Put it on the erect penis right before sex.
- Pull out before the penis softens.
- Hold the condom against the base of the penis before pulling out.
- Use it only once and then throw it away.

How do I get it?

- You do not need a prescription.
- You can buy it over-the-counter or online.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, 18 may get pregnant.
- The most important thing is that you use a condom every time you have sex.

Some Risks

- Irritation
- Allergic reactions (If you are allergic to latex, you can try condoms made of polyurethane).

Does it protect me from sexually transmitted infections (STIs)?

- Yes. Except for abstinence, latex condoms are the best protection against HIV/AIDS and other STIs.

Female Condom

What is it?

- A thin, lubricated pouch that is put into the vagina. It is created from man-made materials. It is not made with natural rubber latex.

How do I use it?

- Put the female condom into the vagina before sex.
- Follow the directions on the package to be sure the penis stays within the condom during sex and does not move alongside the condom.
- Use it only once and then throw it away.

How do I get it?

- You do not need a prescription.

- You can buy it over-the-counter or online.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 21 may get pregnant.
- The most important thing is that you use a condom every time you have sex.

Some Risks

- Irritation
- Allergic reactions

Does it protect me from sexually transmitted infections (STIs)?

- Yes.
- Natural rubber latex condoms for men are highly effective at preventing sexually transmitted infections, including HIV/AIDS, if used correctly. If you are not going to use a male condom, you can use the female condom to help protect yourself and your partner.

Diaphragm with Spermicide
Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.

What is it?

- A dome-shaped flexible disk with a flexible rim.
- Made from latex rubber or silicone.
- It covers the cervix.

How do I use it?

- You need to put spermicidal jelly on the inside of the diaphragm before putting it into the vagina.
- You must put the diaphragm into the vagina before having sex.
- You must leave the diaphragm in place at least 6 hours after having sex.
- It can be left in place for up to 24 hours. You need to use more spermicide every time you have sex.

How do I get it?

- You need a prescription.
- A doctor or nurse will need to do an exam to find the right size diaphragm for you.
- You should have the diaphragm checked after childbirth or if you lose more than 15 pounds. You might need a different size.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 12 may get pregnant.

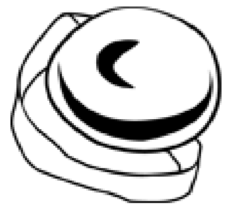
Some Risks

- Irritation, allergic reactions, and urinary tract infection.
- If you keep it in place longer than 24 hours, there is a risk of toxic shock syndrome. Toxic shock is a rare but serious infection.

Does it protect me from sexually transmitted infections (STIs)? No.

Sponge with spermide

Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.



What is it?

- A disk-shaped polyurethane device with the spermicide nonoxynol-9.

How do I use it?

- Put it into the vagina before you have sex.
- Protects for up to 24 hours.
- You do not need to use more spermicide each time you have sex.
- You must leave the sponge in place for at least 6 hours after having sex.
- You must take the sponge out within 30 hours after you put it in. Throw it away after you use it.

How do I get it?

- You do not need a prescription.
- You can buy it over-the-counter.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)O

- Out of 100 women who use this method, 12 to 24 may get pregnant.
- It may not work as well for women who have given birth. Childbirth stretches the vagina and cervix and the sponge may not fit as well.

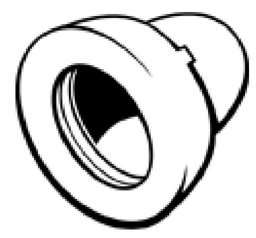
Some Risks

- Irritation
- Allergic reactions
- Some women may have a hard time taking the sponge out.
- If you keep it in place longer than 24-30 hours, there is a risk of toxic shock syndrome. Toxic shock is a rare but serious infection.

Does it protect me from sexually transmitted infections (STIs)? No.

Cervical Cap with Spermicide

Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.



What is it?

- A soft latex or silicone cup with a round rim, which fits snugly around the cervix.

How do I use it?

- You need to put spermicidal jelly inside the cap before you use it.
- You must put the cap in the vagina before you have sex.

- You must leave the cap in place for at least 6 hours after having sex.
- You may leave the cap in for up to 48 hours.
- You do NOT need to use more spermicide each time you have sex.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 17 to 23 may get pregnant.
- It may not work as well for women who have given birth. Childbirth stretches the vagina and cervix and the cap may not fit as well.

Some Risks

- Irritation, allergic reactions, and abnormal Pap test.
- You may find it hard to put in.
- If you keep it in place longer than 48 hours, there is a risk of toxic shock syndrome. Toxic shock is a rare but serious infection.

Does it protect me from sexually transmitted infections (STIs)? No

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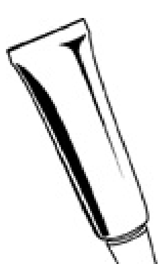
Spermicide Alone
Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.



What is it?

- A foam, cream, jelly, film, or tablet that you put into the vagina.

How do I use it?

- You need to put spermicide into the vagina 5 to 90 minutes before you have sex.
- You usually need to leave it in place at least 6 to 8 hours after sex; do not douche or rinse the vagina for at least 6 hours after sex.
- Instructions can be different for each type of spermicide. Read the label before you use it.

How do I get it?

- You do not need a prescription.
- You can buy it over-the-counter.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 28 may get pregnant.
- Different studies show different rates of effectiveness.

Some Risks

- Irritation
- Allergic reactions
- Urinary tract infection

- If you are also using a medicine for a vaginal yeast infection, the spermicide might not work as well.

Does it protect me from sexually transmitted infections (STIs)? No.

HORMONAL METHODS: Prevent Pregnancy by interfering with ovulation and possibly fertilization of the egg

Oral Contraceptives (Combined Pill)
"The Pill"

What is it?

- A pill that has two hormones (estrogen and progestin) to stop the ovaries from releasing eggs
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.

How do I use it?

- You should swallow the pill at the same time every day, whether or not you have sex.
- If you miss one or more pills, or start a pill pack too late, you may need to use another method of birth control, like a condom

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

Some Side Effects

- Changes in your cycle (period)
- Nausea
- Breast tenderness
- Headache

Less Common Serious Side Effects

- It is not common, but some women who take the pill develop high blood pressure.
- It is rare, but some women will have blood clots, heart attacks, or strokes.

Does it protect me from sexually transmitted infections (STIs)? No.

Oral Contraceptives (Progestin-only)

"The Mini Pill"

What is it?

- A pill that has only one hormone, a progestin.
- It thickens the cervical mucus, which keeps sperm from getting to the egg.
- Less often, it stops the ovaries from releasing eggs.

How do I use it?

- You should swallow the pill at the same time every day, whether or not you have sex.

- If you miss one or more pills, or start a pill pack too late, you may need to use another method of birth control, like a condom.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

Some Side Effects

- Irregular bleeding
- Headache
- Breast tenderness
- Nausea
- Dizziness

Does it protect me from sexually transmitted infections (STIs)? No.

Oral Contraceptives (Extended/Continuous Use)
"Pill"

What is it?

- A pill that has two hormones (estrogen and progestin) to stop the ovaries from releasing eggs.
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.
- These pills are designed so women have fewer or no periods.

How do I use it?

- You should swallow the pill at the same time every day, whether or not you have sex.
- If you miss one or more pills, or start a pill pack too late, you may need to use another method of birth control, like a condom.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

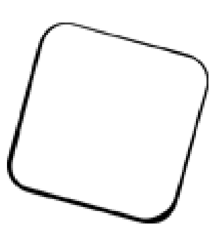
Some Side Effects and Risks

- Risks are similar to other oral contraceptives with estrogen and progestin.
- You may have more light bleeding and spotting between periods than with 21 or 24 day oral contraceptives.
- It may be harder to know if you become pregnant, since you will likely have fewer periods or no periods.

Does it protect me from sexually transmitted infections (STIs)? No.

Patch

What is it?



- This is a skin patch you can wear on the lower abdomen, buttocks, or upper arm or back.
- It has two hormones (estrogen and progestin) that stop the ovaries from releasing eggs
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.

How do I use it?

- You put on a new patch and take off the old patch once a week for 3 weeks (21 total days).
- Don't put on a patch during the fourth week. Your menstrual period should start during this patch-free week.
- If the patch comes loose or falls off, you may need to use another method of birth control, like a condom.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

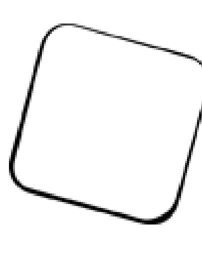
Some Risks

- It will expose you to higher levels of estrogen compared to most combined oral contraceptives.
- It is not known if serious risks, such as blood clots and strokes, are greater with the patch because of the greater exposure to estrogen.

Does it protect me from sexually transmitted infections (STIs)? No.

Vaginal Contraceptive Ring

What is it?



- It is a flexible ring that is about 2 inches around.
- It releases two hormones (progestin and estrogen) to stop the ovaries from releasing eggs.
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.

How do I use it?

- You put the ring into your vagina.
- Keep the ring in your vagina for 3 weeks and then take it out for 1 week. Your menstrual period should start during this ring-free week.
- If the ring falls out and stays out for more than 3 hours, replace it but use another method of birth control, like a condom, until the ring has been in place for 7 days in a row.
- Read the directions and talk to your doctor, nurse or pharmacist about what to do.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

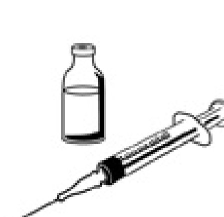
- Out of 100 women who use this method, about 9 may get pregnant.

- Vaginal discharge, discomfort in the vagina, and mild irritation.
- Other risks are similar to oral contraceptives (combined pill).

Does it protect me from sexually transmitted infections (STIs)? No.

Shot/Injection

What is it?



- A shot of the hormone progestin, either in the muscle or under the skin.

How does it work?

- The shot stops the ovaries from releasing eggs
- It also thickens the cervical mucus, which keeps the sperm from getting to the egg.

How do I get it?

- You need one shot every 3 months from a healthcare provider.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, including women who don't get the shot on time, 6 may get pregnant.

Some Risks

- You may lose bone density if you get the shot for more than 2 years in a row.
- Bleeding between periods
- Headaches
- Weight gain
- Nervousness
- Abdominal discomfort

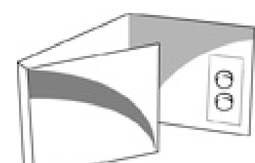
Does it protect me from sexually transmitted infections (STIs)? No.

EMERGENCY CONTRACEPTION: May be used if you did not use birth control or if your regular birth control fails. It should not be used as a regular form of birth control

Plan B, Plan B One- Step and Next Choice (Levonorgestrel)

What is it?

- These are pills with the hormone progestin.
- They help prevent pregnancy after birth control failure or unprotected sex.



How does it work?

- It works mainly by stopping the release of an egg from the ovary. It may also work by preventing fertilization of an egg (the uniting of sperm with the egg) or by preventing attachment (implantation) to the womb (uterus).
- For the best chance for it to work, you should start taking the pill(s) as soon as possible after unprotected sex.
- You should take emergency contraception within three days after having unprotected sex.

How do I get it?

- You can buy **Plan B One-Step** over-the-counter. You do not need a prescription.
- You can buy Plan B and Next Choice over-the-counter if you are age 17 years or older. If you are younger than age 17, you need a prescription.

Chance of getting pregnant

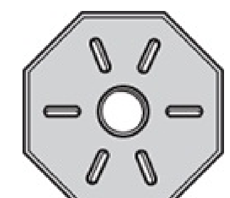
- Seven out of every 8 women who would have gotten pregnant will not become pregnant after taking Plan B, Plan B One-Step, or Next Choice.

Some Risks

- Nausea, vomiting, abdominal pain, fatigue and headache

Does it protect me from sexually transmitted infections (STIs)? No.

Ella (ulipristal acetate)



What is it?

- A pill that blocks the hormone progesterone.
- It helps prevent pregnancy after birth control failure or unprotected sex.
- It works mainly by stopping or delaying the ovaries from releasing an egg. It may also work by changing the lining of the womb (uterus) that may prevent attachment (implantation).

How do I use it?

- For the best chance for it to work, you should take the pill as soon as possible after unprotected sex.
- You should take Ella within five days after unprotected sex.

How do I get it?

- You need a prescription.

Chance of getting pregnant

- Six or 7 out of every 10 women who would have gotten pregnant will not become pregnant after taking ella.

Some Risks

- Headache
- Nausea
- Abdominal pain
- Menstrual pain
- Tiredness
- Dizziness

Does it protect me from sexually transmitted infections (STIs)? No.

IMPLANTED DEVICES: Inserted/implanted into the body and can be kept in place for several years

Copper IUD

What is it?

- A T-shaped device containing copper that is put into the uterus by a healthcare provider.

How does it work?

- The IUD prevents sperm from reaching the egg, from fertilizing the egg, and may prevent the egg from attaching (implanting) in the womb (uterus).
- It does not stop the ovaries from making an egg each month.
- The Copper IUD can be used for up to 10 years.
- After the IUD is taken out, it is possible to get pregnant.

How do I get it?

- A doctor or other healthcare provider needs to put in the IUD.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Side Effects

- Cramps
- Irregular bleeding

Uncommon Risks

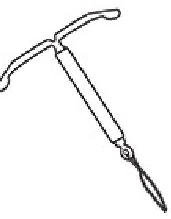
- Pelvic inflammatory disease
- Infertility

Rare Risk

- IUD is stuck in the uterus or found outside the uterus.
- Life-threatening infection.

Does it protect me from sexually transmitted infections (STIs)? No.

IUD with progestin



What is it?

- A T-shaped device containing a progestin that is put into the uterus by a healthcare provider.

How does it work?

- It may thicken the mucus of your cervix, which makes it harder for sperm to get to the egg, and also thins the lining of your uterus.
- After a doctor or other healthcare provider puts in the IUD, it can be used for up to 3 to 5 years, depending on the type.
- After the IUD is taken out, it is possible to get pregnant.

How do I get it?

- A doctor or other healthcare provider needs to put in the IUD.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Side Effects

- Irregular bleeding
- No periods
- Abdominal/pelvic pain
- Ovarian cysts

Uncommon Risks

- Pelvic inflammatory disease
- Infertility

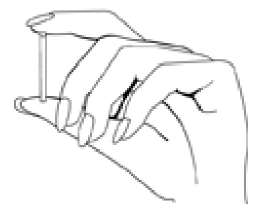
Rare Risk

- IUD is stuck in the uterus or found outside the uterus
- Life-threatening infection.

Does it protect me from sexually transmitted infections (STIs)? No.

Implantable Rod

What is it?



- A thin, matchstick-sized rod that contains the hormone progestin.
- It is put under the skin on the inside of your upper arm.

How does it work?

- It stops the ovaries from releasing eggs.
- It thickens the cervical mucus, which keeps sperm from getting to the egg.
- It can be used for up to 3 years.

How do I get it?

- After giving you local anesthesia, a doctor or nurse will put it under the skin of your arm with a special needle.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Side Effects

- changes in bleeding patterns
- weight gain
- breast and abdominal pain

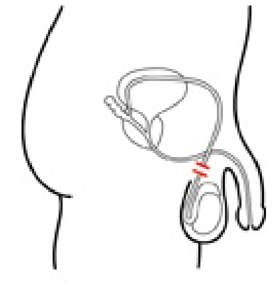
Does it protect me from sexually transmitted infections (STIs)? No.

PERMANENT METHODS: For people who are sure they never want to have a child or do not want any more children.

Sterilization Surgery for Men (Vasectomy)

This method is for men who are sure they never want to have a child or do not want any more children. If you are thinking about reversal, vasectomy may not be right for you. Sometimes it is possible to reverse the operation, but there are no guarantees. Reversal involves complicated surgery that might not work.

What is it?



- This is a surgery a man has only once.
- It is permanent

How does it work?

- A surgery blocks a man's vas deferens (the tubes that carry sperm from the testes to other glands).
- Semen (the fluid that comes out of a man's penis) never has any sperm in it.
- It takes about three months to clear sperm out of a man's system. You need to use another form of birth control until a test shows there are no longer any sperm in the seminal fluid.

How do I get it?

- A man needs to have surgery.
- Local anesthesia is used.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women whose partner has had a vasectomy, less than 1 may get pregnant.

Some Risks

- Pain
- Bleeding
- Infection

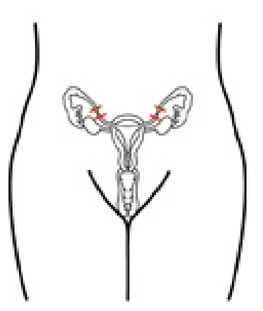
Does it protect me from sexually transmitted infections (STIs)? No.

The success of reversal surgery depends on:

- The length of time since the vasectomy was performed.
- Whether or not antibodies to sperm have developed.
- The method used for vasectomy
- Length and location of the segments of vas deferens that were removed or blocked.

Sterilization Surgery for Women
Surgical Implant (also called trans-abdominal surgical sterilization)

What is it?



- A device is placed on the outside of each fallopian tube.

How does it work?

- One way is by tying and cutting the tubes — this is called tubal ligation. The fallopian tubes also can be sealed using an instrument with an electrical current. They also can be closed with clips, clamps, or rings. Sometimes, a small piece of the tube is removed.
- The woman's fallopian tubes are blocked so the egg and sperm can't meet in the fallopian

tube. This stops you from getting pregnant.

- This is a surgery a woman has only once.
- It is permanent.

How do I get it?

- This is a surgery you ask for.
- You will need general anesthesia.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

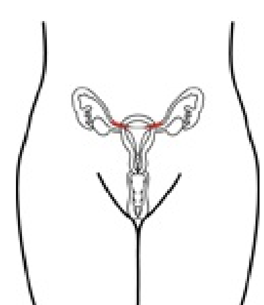
Some Risks

- Pain
- Bleeding
- Infection or other complications after surgery
- Ectopic (tubal) pregnancy

Does it protect me from sexually transmitted infections (STIs)? No.

Sterilization Implant for Women (Transcervical Surgical Sterilization Implant)

What is it?



- Small flexible, metal coil that is put into the fallopian tubes through the vagina.
- The device works by causing scar tissue to form around the coil. This blocks the fallopian tubes and stops you from getting pregnant.

How does it work?

- The device is put inside the fallopian tube with a special catheter.
- You need to use another birth control method during the first 3 months. You will need an X-ray to make sure the device is in the right place.
- It is permanent.

How do I get it?

- The devices are placed into the tubes using a camera placed in the uterus.
- Once the tubes are found, the devices are inserted. No skin cutting (incision) is needed.
- You may need local anesthesia.
- Since it is inserted through the vagina, you do not need an incision (cutting).

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Risks

- Mild to moderate pain after insertion

- Ectopic (tubal) pregnancy

Does it protect me from sexually transmitted infections (STIs)? No.

To Learn More:
This guide should not be used in place of talking to your doctor or reading the label for your product. The product and risk information may change.

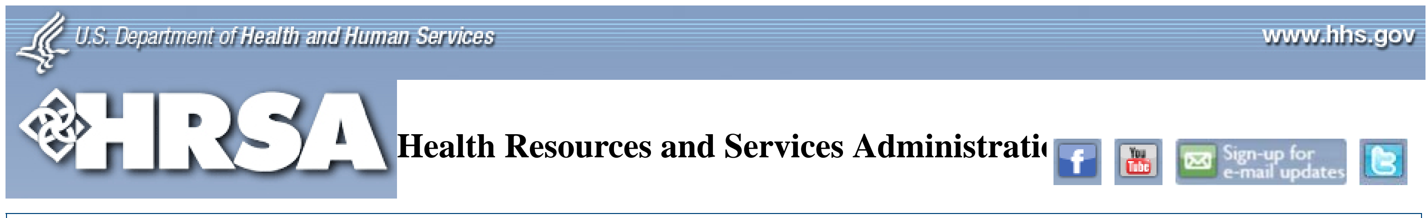
To get the most recent information for your birth control go to:

Drugs:
http://www.accessdata.fda.gov/scripts/cder/drugsatfda (type in the name of your drug)

Devices:
http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRL/LSTSimpleSearch.cfm
(type in the name of your device)

Updated May 2013

Exhibit C



Women's Preventive Services Guidelines

Affordable Care Act Expands Prevention Coverage for Women's Health and Well-Being

The Affordable Care Act – the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services and by eliminating cost sharing for those services. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider.

Women's Preventive Services Guidelines Supported by the Health Resources and Services Administration

Under the Affordable Care Act, women's preventive health care – such as mammograms, screenings for cervical cancer, prenatal care, and other services – generally must be covered by health plans with no cost sharing. However, the law recognizes and HHS understands the need to take into account the unique health needs of women throughout their lifespan.

The HRSA-supported health plan coverage guidelines, developed by the Institute of Medicine (IOM), will help ensure that women receive a comprehensive set of preventive services without having to pay a co-payment, co-insurance or a deductible. HHS commissioned an IOM study to review what preventive services are necessary for women's health and well-being and therefore should be considered in the development of comprehensive guidelines for preventive services for women. HRSA is supporting the IOM's recommendations on preventive services that address health needs specific to women and fill gaps in existing guidelines.

Health Resources and Services Administration Women's Preventive Services Guidelines

Non-grandfathered plans (plans or policies created or sold after March 23, 2010, or older plans or policies that have been changed in certain ways since that date) generally are required to provide coverage without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012.

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits.	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.* (see note)

Learn More

Clinical Preventive Services for Women: Closing the Gaps Institute of Medicine report

Prevention

	section 2713.	
Screening for gestational diabetes.	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing.	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections.	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus.	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling. ** (see note)	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed.
Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	

** Refer to guidance issued by the Center for Consumer Information and Insurance Oversight entitled Affordable Care Act Implementation FAQs, Set 12, Q10. In addition, refer to recommendations in the July 2011 IOM report entitled Clinical Preventive Services for Women: Closing the Gaps concerning distinct preventive services that may be obtained during a well-woman preventive services visit.*

*** The guidelines concerning contraceptive methods and counseling described above do not apply to women who are participants or beneficiaries in group health plans sponsored by religious employers. Effective August 1, 2013, a religious employer is defined as an employer that is organized and operates as a non-profit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code. HRSA notes that, as of August 1, 2013, group health plans established or maintained by religious employers (and group health insurance coverage provided in connection with such plans) are exempt from the requirement to cover contraceptive services under section 2713 of the Public Health Service Act, as incorporated into the Employee Retirement Income Security Act and the Internal Revenue Code. HRSA also notes that, as of January 1, 2014, accommodations are available to group health plans established or maintained by certain eligible organizations (and group health insurance coverage provided in connection with such plans), as well as student health insurance coverage arranged by eligible organizations, with respect to the contraceptive coverage requirement. See Federal Register Notice: Coverage of Certain Preventive Services Under the Affordable Care Act (PDF - 327 KB)*

Exhibit D

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News Release

FOR IMMEDIATE RELEASE
January 20, 2012

Contact: HHS Press Office
(202) 690-6343

A statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius

In August 2011, the Department of Health and Human Services issued an interim final rule that will require most health insurance plans to cover preventive services for women including recommended contraceptive services without charging a co-pay, co-insurance or a deductible. The rule allows certain non-profit religious employers that offer insurance to their employees the choice of whether or not to cover contraceptive services. Today the department is announcing that the final rule on preventive health services will ensure that women with health insurance coverage will have access to the full range of the Institute of Medicine's recommended preventive services, including all FDA -approved forms of contraception. Women will not have to forego these services because of expensive co-pays or deductibles, or because an insurance plan doesn't include contraceptive services. This rule is consistent with the laws in a majority of states which already require contraception coverage in health plans, and includes the exemption in the interim final rule allowing certain religious organizations not to provide contraception coverage. Beginning August 1, 2012, most new and renewed health plans will be required to cover these services without cost sharing for women across the country.

After evaluating comments, we have decided to add an additional element to the final rule. Nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan, will be provided an additional year, until August 1, 2013, to comply with the new law. Employers wishing to take advantage of the additional year must certify that they qualify for the delayed implementation. This additional year will allow these organizations more time and flexibility to adapt to this new rule. We intend to require employers that do not offer coverage of contraceptive services to provide notice to employees, which will also state that contraceptive services are available at sites such as community health centers, public clinics, and hospitals with income-based support. We will continue to work closely with religious groups during this transitional period to discuss their concerns.

Scientists have abundant evidence that birth control has significant health benefits for women and their families, is documented to significantly reduce health costs, and is the most commonly taken drug in America by young and middle-aged women. This rule will provide women with greater access to contraception by requiring coverage and by prohibiting cost sharing.

This decision was made after very careful consideration, including the important concerns some have raised about religious liberty. I believe this proposal strikes the appropriate balance between respecting religious freedom and increasing access to important preventive services. The administration remains fully committed to its partnerships with faith-based organizations, which promote healthy communities and serve the common good. And this final rule will have no impact on the protections that existing conscience laws and regulations give to health care providers.

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Note: All HHS news releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

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Last revised: February 2, 2012

Exhibit E

Opening Remarks

Julio Frenk
Dean, Harvard School of Public Health

Moderator

Sharon Begley
Senior U.S. Health & Science Correspondent, Reuters

Expert Participants

Kathleen Sebelius
Secretary of the U.S. Department of Health and Human Services

A Conversation with Kathleen Sebelius

U.S. Secretary of Health and Human Services

Summary

Kathleen Sebelius is the 21st Secretary of the Department of Health and Human Services (HHS). Before her Cabinet appointment in April, 2009, she served as Governor of Kansas beginning in 2003, where she was named one of America's Top Five Governors by *Time Magazine*. From 1995 to 2003, she served as Kansas Insurance Commissioner. She was a member of the Kansas House of Representatives from 1987 to 1995. *Forbes* has named Secretary Sebelius one of

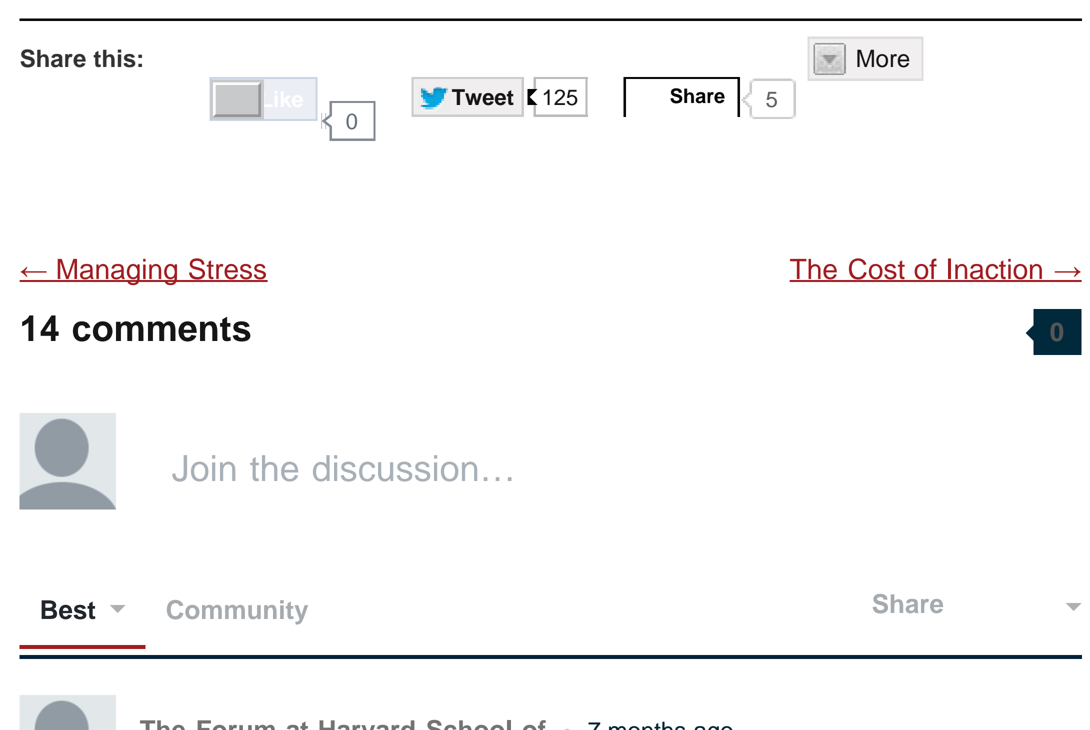
the 100 most powerful women in the world.

Presented in Collaboration with Reuters

Background Articles

- U.S. Department of Health and Human Services

Image Credit: Image of Secretary Sebelius courtesy of HHS.



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The Forum at Harvard School of • 7 months ago

QUESTION FROM LIVE CHAT
with regards to ACA, are there any policies specifically related to preventive health measures in maternal health and pediatric health? Also,any policies that would support research into better pediatric health outcomes?

| • Reply • Share ›

The Forum at Harvard School of • 7 months ago

QUESTION FROM LIVE CHAT
We are gathering information for a needle exchange program. Is it possible to ask Sec. Sebelius about the success she's seen with similar programs?

Exhibit F

The Center for Consumer Information & Insurance Oversight

Amendment to Regulation on “Grandfathered” Health Plans under the Affordable Care Act

On June 17, 2010, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) issued the “grandfather” regulation which, by addressing how health plans can retain a “grandfathered” exemption from certain new requirements, helps protect Americans’ ability to keep their current plan if they like it. At the same time, Americans in grandfathered plans will receive many of the added benefits that the new law provides. The regulation also minimizes market disruption and helps put us on a path toward the competitive, patient-centered market of the future.

The grandfather regulation includes a number of rules for determining when changes to a health plan cause the plan to lose its grandfathered status. For example, plans could lose their grandfathered status if they choose to make certain significant changes that reduce benefits or increase costs to consumers. This amendment modifies one aspect of the original regulation.

Previously, one of the ways an employer group health plan could lose its grandfathered status was if the employer changed issuers – switching from one insurance company to another. The original regulation only allowed self-funded plans to change third-party administrators without necessarily losing their grandfathered plan status. Today’s amendment allows all group health plans to switch insurance companies and shop for the same coverage at a lower cost while maintaining their grandfathered status, so long as the structure of the coverage doesn’t violate one of the other rules for maintaining grandfathered plan status..

What does this mean for you?

The purpose of the grandfather regulation is to help people keep existing health plans that are working for them. This amendment furthers that goal by allowing employers to offer the same level of coverage through a new issuer and remain grandfathered, as long as the change in issuer does not result in significant cost increases, a reduction in benefits, or other changes described in the original grandfather rule.

Why did HHS, Labor and Treasury make this change?

The Departments received many comments on the provision in the original grandfather rule stating that a group health plan would relinquish grandfathered status if it changed issuers or policies. This change was made in response to those comments for the following reasons:

1. There are circumstances where a group health plan may need to make administrative changes that don’t affect the benefits or costs of a plan. For example, an insurer may stop offering coverage in a market. Or a company may change hands. In those cases, the employer can maintain grandfathered status for their employee plan under this amendment.
2. Comments expressed concern that the original provision could have the inadvertent effect of interfering with health care cost containment. If an employer has to stay with the same insurance company to keep the benefits of having a grandfathered plan, the insurance company has undue and unfair leverage in negotiating the price of coverage renewals. Allowing employers to shop around can help keep costs down while ensuring individuals can keep the coverage they have.
3. Some employers buy coverage from insurance companies; others “self-insure,” meaning that they pay claims themselves but usually hire a third-party administrator (TPA) to handle the paperwork. Usually only large companies can self-insure. Before this amendment, self-insured plans could change the company hired to handle the paperwork without losing grandfathered status as long as the benefits and costs of the plan stayed the same, while an employer that just changed insurance companies while maintaining the same benefits under their plan could not do so. Under this amendment, all employers have the flexibility to keep their grandfathered plan but change insurance company or third-party administrator.

What types of plans does this affect?

The amendment affects insured group health plans.

A change of issuers in the individual market would still result in the loss of grandfathered status.

How many plans will this affect?

The Departments expect that this amendment will result in a small increase in the number of plans retaining their grandfathered status relative to the estimates made in the grandfathering regulation.

The Departments did not produce a range of estimates for the number of affected entities given considerable uncertainty about the response to this amendment.

Exhibit G

Statistics about Business Size (including Small Business) from the U.S. Census Bureau

The Census Bureau does not define small or large business, but provides statistics that allow users to define business categories in any of several ways:

Employers and nonemployers | Employment size of firms | Employment size of establishments | Receipts size of firms

Independently, the Small Business Administration defines size standards for each NAICS industry [PDF] to determine which businesses are eligible for its programs.

Employers and Nonemployers

BusinessUSA
Find the resources to jump start your business @ Business USA

About three quarters of all U.S. business firms have no payroll. Most are self-employed persons operating unincorporated businesses, and may or may not be the owner's principal source of income. Because nonemployers account for only about 3.4 percent of business receipts, they are not included in most business statistics, for example, most reports from the Economic Census.

Nonemployer Statistics annually classify nonemployer firms by industry and geographic area (U.S., states, counties, and metropolitan areas.)

Table 1. Employers and Nonemployers, 2007

	Firms	Estab-lish-ments	Sales or Receipts ($1,000)
All firms	27,757,676	29,413,039	30,738.533,467
Nonemployers (firms with no payroll)	21,708,021	21,708,021	991,791,563
Employers (firms with payroll)	6,049,655	7,705,018	29,746,741,904

Employment Size of Firms

Table 2a. Employment Size of Employer and Nonemployer Firms, 2008

Introductory text includes scope and methodology. These data are also available by industry and state. Table includes both establishments with payroll and nonemployers. For descriptions of column headings and rows (industries), click on the appropriate underlined element in the table.

Employment size of enterprise	Firms	Estab-lish-ments	Paid employees	Annual payroll ($1,000)	Sales or Receipts ($1,000)
All firms	**27,281,452**	**28,952,489**	**120,903,551**	**5,130,509,178**	**n/a**
Nonemployer firms	21,351,320	21,351,320	n/a	n/a	962,791,527
Employer firms	**5,930,132**	**7,601,169**	**120,903,551**	**5,130,509,178**	**n/a**
Firms with 1 to 4 employees (or with no employees as of Mar 12)	3,617,764	3,624,614	6,086,291	232,062,907	n/a
Firms with 5 to 9 employees	1,044,065	1,056,947	6,878,051	222,504,912	n/a
Firms with 10 to 19 employees	633,141	667,463	8,497,391	293,534,352	n/a
Firms with 20 to 99 employees	526,307	705,430	20,684,691	774,589,335	n/a
Firms with 100 to 499 employees	90,386	359,902	17,547,567	706,476,693	n/a
Firms with 500 employees or more	18,469	1,186,813	61,209,560	2,901,340,979	n/a
Firms with 500 to 749 employees	6,060	72,676	3,681,760	156,491,764	n/a
Firms with 750 to 999 employees	3,038	48,005	2,617,087	114,635,897	n/a
Firms with 1,000 to 1,499 employees	3,044	64,556	3,720,654	167,658,791	n/a
Firms with 1,500 to 1,999 employees	1,533	45,062	2,653,392	121,800,728	n/a
Firms with 2,000 to 2,499 employees	904	36,081	2,011,244	94,406,916	n/a
Firms with 2,500 to 4,999 employees	1,934	120,416	6,726,611	329,188,349	n/a
Firms with 5,000 employees or more	1,956	800,017	39,798,812	1,917,158,534	n/a
Firms with 5,000 to 9,999 employees	975	121,835	6,773,466	337,598,036	n/a
Firms with 10,000 employees or more	981	678,182	33,025,346	1,579,560,498	n/a

n/a - Receipts data are available for employers only for the years for which an economic census is taken (2007, 2002, 1997).

Source: Statistics of U.S. Businesses (See industry and state detail) and Nonemployer Statistics

Table 2b. Employment Size of Employer and Nonemployer Firms, 2007

Introductory text includes scope and methodology.Table includes both establishments with payroll and nonemployers. For descriptions of column headings and rows (industries), click on the appropriate underlined element in the table.

Employment size of enterprise	Firms	Estab-lish-	Paid employees	Annual payroll	Sales or Receipts

		ments		($1,000)	($1,000)
All firms	**27,757,676**	**29,413,039**	**120,604,265**	**5,026,778,232**	**30,738,533,467**
Nonemployer firms	21,708,021	21,708,021	n/a	n/a	991,791,563
Employer firms	**6,049,655**	**7,705,018**	**120,604,265**	**5,026,778,232**	**29,746,741,904**
Firms with 1 to 4 employees (or with no employees as of Mar 12)	3,705,275	3,710,700	6,139,463	234,921,325	1,434,680,823
Firms with 5 to 9 employees	1,060,250	1,073,875	6,974,591	222,419,546	1,144,930,232
Firms with 10 to 19 employees	644,842	682,410	8,656,182	292,088,277	1,395,498,431
Firms with 20 to 99 employees	532,391	723,385	20,922,960	768,546,555	3,792,920,977
Firms with 100 to 499 employees	88,586	355,853	17,173,728	686,862,018	3,612,050,221
Firms with 500 employees or more	18,311	1,158,795	60,737,341	2,821,940,511	18,366,661,220
Firms with 500 to 749 employees	6,094	71,702	3,695,682	152,059,022	800,475,934
Firms with 750 to 999 employees	2,970	45,990	2,561,972	109,833,289	636,199,229
Firms with 1,000 to 1,499 employees	2,916	59,311	3,552,259	153,957,992	792,993,702
Firms with 1,500 to 1,999 employees	1,542	46,221	2,664,416	120,606,441	695,739,349
Firms with 2,000 to 2,499 employees	942	36,388	2,094,728	94,001,450	544,038,807
Firms with 2,500 to 4,999 employees	1,920	118,282	6,687,266	320,640,371	1,979,674,138
Firms with 5,000 employees or more	1,927	780,901	39,481,018	1,870,841,946	12,917,540,061
Firms with 5,000 to 9,999 employees	952	115,222	6,628,415	324,791,017	2,263,012,551
Firms with 10,000 employees or more	975	665,679	32,852,603	1,546,050,929	10,654,527,510

While most of these data are published every year, receipts data are available for employers only for the years for which an economic census is taken (2007, 2002, 1997).

Source: Statistics of U.S. Businesses (See industry and state detail) and Nonemployer Statistics

Economic Census Establishment and Firm Size reports, present national data classified by NAICS industry.

Statistics of U.S. Businesses is published each year for the U.S., states, metropolitan areas, and, for selected years only, counties. Classification is by the employment size of the overall enterprise, but by the location and NAICS industry of the establishment. Customized tabulations are also available.

U.S. - All industries - by Year

Introductory text includes scope and methodology. Table includes only establishments with payroll. Nonemployers are shown separately. For descriptions of column headings and rows (industries), click on the appropriate underlined element in the table.

More data	Year	Firms by employment size of enterprise				Paid employees by employment size of enterprise			
		Total	20 +	100 +	500 +	Total	20 +	100 +	500 +
more	**2008**	**5,930,132**	**10.7%**	**1.8%**	**0.3%**	**120,903,551**	**82.2%**	**65.1%**	**50.6%**
more	2007	6,049,655	10.6%	1.8%	0.3%	120,604,265	81.9%	64.6%	50.4%
more	2006	6,022,127	10.7%	1.8%	0.3%	119,917,165	82.0%	64.4%	49.8%
more	2005	5,983,546	10.5%	1.8%	0.3%	116,317,003	81.7%	64.1%	49.6%
more	2004	5,885,784	10.7%	1.8%	0.3%	115,074,924	81.6%	63.6%	49.1%
more	2003	5,767,127	10.7%	1.8%	0.3%	113,398,043	81.6%	63.8%	49.3%
more	2002	5,697,759	10.7%	1.7%	0.3%	112,400,654	81.7%	64.0%	49.9%
more	2001	5,657,774	11.0%	1.8%	0.3%	115,061,184	82.1%	64.4%	50.1%
more	2000	5,652,544	10.9%	1.8%	0.3%	114,064,976	82.0%	64.2%	49.9%
more	1999	5,607,743	10.7%	1.7%	0.3%	110,705,661	81.6%	63.8%	49.7%
more	1998	5,579,177	10.6%	1.7%	0.3%	108,117,731	81.2%	63.3%	49.1%
	1997	5,541,918	10.5%	1.7%	0.3%	105,299,123	80.9%	62.7%	48.2%
	1996	5,478,047	10.4%	1.7%	0.3%	102,187,297	80.5%	62.3%	48.0%
	1995	5,369,068	10.5%	1.7%	0.3%	100,314,946	80.5%	62.1%	47.5%
	1994	5,276,964	10.2%	1.7%	0.3%	96,721,594	80.2%	61.9%	47.3%
	1993	5,193,642	10.2%	1.7%	0.3%	94,773,913	79.9%	61.5%	46.9%
	1992	5,095,356	10.3%	1.6%	0.3%	92,825,797	79.8%	61.3%	47.0%
	1991	5,051,025	10.3%	1.6%	0.3%	92,307,559	79.7%	61.2%	46.9%
	1990	5,073,795	10.6%	1.7%	0.3%	93,469,275	79.8%	60.8%	46.3%
	1989	5,021,315	10.5%	1.7%	0.3%	91,626,094	79.7%	60.7%	46.1%
	1988	4,954,645	10.3%	1.6%	0.3%	87,844,303	79.1%	60.0%	45.5%

Source: Statistics of U.S. Businesses

Employment Size of Establishments

A number of sources provide information by employment size of establishment: several reports from with national data from the 2007 Economic Census, and the annual County Business Patterns which includes statistics by state. metro area, county, and ZIP Code. Most scholars prefer to define small business in terms of the size of the entire company or firm, not individual establishments. For example, most researchers would prefer to classify a large fast-food chain as a large company rather than as a collection of small establishments.

Economic Census Establishment and Firm Size reports, present national data classified by NAICS industry.

Receipt Size of Firms

Table 3. Receipt Size of Employer Firms, 2007

See the explanatory text for methodology, contact names, and other data available. For descriptions of column heading, click on that element in the table.

Receipts Size of Enterprise	Firms	Estab-lish-ments	Paid employees	Annual payroll ($1,000)	Sales or Receipts ($1,000)
Employer firms	**6,049,655**	**7,705,018**	**120,604,265**	**5,026,778,232**	**29,746,741,904**
Less than $100,000	1,305,233	1,305,986	1,819,621	25,960,943	61,210,592
$100,000-499,999	2,394,168	2,401,076	8,146,397	173,879,138	608,894,770
$500,000-999,999	908,635	923,958	6,723,289	182,060,621	641,553,968
$1,000,000-2,499,999	758,595	813,052	10,317,058	322,308,981	1,177,399,522
$2,500,000-4,999,999	311,271	376,161	7,757,850	276,120,363	1,086,482,976
$5,000,000-7,499,999	115,476	164,063	4,530,513	172,852,732	701,673,005
$7,500,000-9,999,999	58,822	95,294	3,086,011	121,758,219	508,020,210
$10,000,000-14,999,999	62,468	119,982	4,338,364	173,887,341	758,667,466
$15,000,000-19,999,999	32,292	76,520	2,961,726	120,919,167	556,844,154
$20,000,000-24,999,999	20,137	54,079	2,201,318	92,339,910	448,894,669
$25,000,000-29,999,999	13,678	41,723	1,800,640	75,540,186	373,746,067
$30,000,000-34,999,999	9,807	31,918	1,507,405	61,765,492	317,129,331
$35,000,000-39,999,999	7,289	27,176	1,230,398	52,340,200	272,513,425
$40,000,000-44,999,999	5,767	23,604	1,075,209	45,739,259	243,892,639
$45,000,000-49,999,999	4,547	20,055	943,369	39,528,117	215,490,512
$50,000,000-74,999,999	14,026	72,501	3,573,919	153,521,056	852,712,438
$75,000,000-99,999,999	6,839	49,649	2,463,475	106,072,301	591,372,207
$100,000,000 or more	20,605	1,108,221	56,127,703	2,830,184,206	20,330,243,953

Source: Statistics of U.S. Businesses, 2007

Statistics of U.S. Businesses tables showing receipt size by NAICS industry *of the establishment* are accessible as spreadsheets for 2007, 2002 and 1997. Receipts size detail is less than shown in Establishment and Firm Size reports cited below.

Economic Census Establishment and Firm Size reports, present national data classified by the NAICS industry *of the establishment*.

Corresponding data for 1992, from 1992 Enterprise Statistics, differ somewhat in methodology. The PDF presents these statistics by SIC industry *of the parent company*. (Enterprise Statistics was not funded for years after 1992.)

[PDF] or denotes a file in Adobe's Portable Document Format. To view the file, you will need the Adobe® Reader® available **free** from Adobe.

Exhibit H

The Church of Kathleen Sebelius

In the church of Kathleen Sebelius, there is little room for dissent. "We are in a war," the Health and Human Services Secretary declared to cheers at a recent NARAL Pro-Choice America fund-raiser. Give the lady her due: Her actions mostly match her words.

Mrs. Sebelius's militancy explains the shock her allies are now feeling after last Wednesday's decision to overrule the Food and Drug Administration on Plan B, a morning-after pill. The FDA had proposed allowing over-the-counter sales, which would give girls as young as 11 or 12 access without either a prescription or a parent. Now the secretary's allies are howling about her "caving in" to the Catholic bishops.

On this score they needn't worry. Notwithstanding the unexpected burst of common sense on Plan B, the great untold story remains the intolerance so beloved of self-styled progressives. In this Mrs. Sebelius has proved herself one of the administration's most faithful practitioners: here watering down conscience protections for nurses and doctors who don't want to participate in abortions; there yanking funding for a top-rated program for victims of sexual trafficking run by the Catholic bishops, because they will not sign on to the NARAL agenda; soon to impose a new HHS mandate that will require health-insurance plans to cover contraception, sterilization and drugs known to induce abortion.

Alas for her president, her zeal for this agenda has yielded two unintended consequences. Within her party, it is creating a rift between the Planned Parenthood wing and the president's Catholic and religious supporters. Outside her party, it is illuminating the danger of equating bigger government with a more just society.

Thus far, attention has mostly focused on the politics. One reason is that even Catholics who supported President Obama on his signature health bill recognize the contraceptive mandate as a bridge too far. These include the Catholic Health Association's Sr. Carol Keehan, whose well-publicized embrace of the Affordable Care Act gave the president critical cover when he needed it. Others simply question whether forcing Catholic hospitals to drop health insurance for their employees rather than submit to Madam Sebelius's bull is really the image the president wants during a tough re-election year.

Then there are the Catholic bishops. Just two years ago, many seemed to regard ObamaCare as a compassionate piece of legislation if only a few provisions (e.g., conscience rights and abortion funding) could be tweaked. Now they are learning the real problem is the whole thing is built on force—from the individual mandate and doctors' fees to the panels deciding what treatment grandma is entitled to. The awakening has led to a new bishops' committee on religious liberty, and tough, unprecedented criticism.

Predictably the press has been treating all this as a purely Catholic battle. If the church looms large here, that is because Catholic institutions have always been at the fore of social service. Still, it would be nice to come across a story that recognized that even if HHS were to widen the religious exemption (it's so narrow Jesus Christ wouldn't qualify) the new contraceptive mandate would still be imposed on non-Catholic as well as Catholic individuals and insurers.

Whether you approve or disapprove of contraception or sterilization is beside the point. Today nine out of 10 employer plans offer what Mrs. Sebelius wants them to. The point is whether it is right or necessary for Mrs. Sebelius to use the federal government to bring the other 10% to heel.

There was a day when liberals and libertarians appreciated the importance of upholding the freedoms of people and groups with unpopular views. No longer. As government expands, religious liberty is reduced to a special "exemption" and concerns about government coercion are dismissed, in the memorable words of Nancy Pelosi, as "this conscience thing."

"Religious liberty is better seen as more a liberty issue than a religion issue," says Bill Mumma of the Becket Fund for Religious Liberty. "The more we drive religious and private associations off the public square, the more that space will be occupied by government."

Of course, some might answer that they object to lots of things their money underwrites—say, the war in Iraq. Mrs. Sebelius's HHS rule, however, doesn't involve tax dollars: It involves forcing Americans to spend their private dollars on things they deem unconscionable. How far this is from the understanding in 1776 that the way to uphold liberty and keep these conflicts to a minimum was to keep government small and limited.

A new TV ad from CatholicVote.org features a little girl. "Dear President Obama," she says. "Can I ask you a question? Why are you trying to force my church and my school to pay for things that we don't even believe in?"

It's a good question. Apparently it's not enough that contraception be legal, cheap and available. As Mrs. Sebelius illustrates, modern American liberalism cannot rest until those who object are forced to underwrite it.

Write to MainStreet@wsj.com.

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Exhibit I

104th NAACP Annual Conference

As prepared for delivery

Orlando, Florida
July 16, 2013

Thank you, Hilary, for that introduction. Thank you, President Jealous, Chairwoman Brock, and the Board of Directors, for inviting me. And thank you all for being here and for your service with one of the most important civil rights organizations in America.

Before I begin, I'd like to take a moment and thank our Surgeon General, Dr. Regina Benjamin, whose last day as America's doctor is today. Dr. Benjamin served with distinction – leading our first-of-its-kind National Prevention Strategy that helps move our country from one focused on sickness and disease to one based on wellness. She's also led our Public Health Service Commissioned Corps during public health emergencies. I'm grateful for her service, and pleased she will be here tomorrow.

I want to also thank Secretary Donovan and Attorney General Holder for their leadership and collaboration in President Obama's Cabinet. We know that housing, health, and a just society are key elements in the President's opportunity agenda to strengthen the middle class and help more people join the middle class.

Creating more possibilities for everyone to reach his or her full potential is why we all get up and go to work every day. That's how we bridge the meaning of our inalienable rights of life, liberty, and the pursuit of happiness to the realities of our time – as President Obama discussed in his second inaugural address.

And today, I'd like to talk about how our Department – the Department of Health and Human Services – is moving forward on the unfinished work of securing those rights. The rights may be self-evident, but they are not self-executing, as the President reminded us after a historic re-election that all of you helped make happen.

One critical step we're taking is expanding quality early education for our children.

We know that when children aren't safe and secure and in a learning environment, they can fall far behind their peers. But when they have social, emotional, and educational support in their earliest years, the benefits can last a lifetime.

Like with many of you and your children, I've seen the importance of early childhood development with my own sons, who were 2 and 5 when I was first elected to the Kansas legislature. I see it now as a grandmother of an 11-month-old grandson, with two working parents.

That's why we're working so closely with our great partners in the Department of Education, led by my good friend, Arne Duncan, to strengthen and expand early learning programs, especially for low-income families.

We're expanding home-visiting programs to support new parents and caregivers. We're strengthening Early Head Start and Head Start to help more children develop critical social and emotional skills that make a lifetime difference. Our babies and toddlers can become lifelong learners if their parents and caregivers can help them make a great start.

The President's historic plan for birth to age 5 also includes providing every child in America access to affordable preschool, which helps our children perform better in school and saves hard-working families hard-earned dollars in daycare costs.

We know early learning is a child's gateway to a better life. And it benefits us all. We all benefit from our young people going to school, starting a career, and achieving their dreams.

But we need your help reinforcing that message with policymakers and the public, and highlighting what's at stake.

If we shortchange our children, we shortchange our future. We can't let that happen.

And that brings me to another area of unfinished work that does right by our children and keeps the doors of opportunity open to them. We do our children and country no justice if we do nothing to stop the violence that plagues our communities.

I know that's been on our minds too often recently, but especially over the last couple of days. The death of Trayvon Martin was a tragedy for his family, but also for our country. And so are the tragedies of all the children we have lost because of gun violence before and since Trayvon was killed.

We pray for his family and respect their call for calm reflection. And we follow the President in asking ourselves if we're doing all we can to prevent future tragedies – from mass school shootings to the daily violence on street corners – from happening again.

That is a job for all of us. We can all widen the circle of compassion and understanding in our own communities.

At our Department we're asking how public health agencies like the CDC and NIH can better research and monitor gun violence-related injuries and deaths. We want to better determine risk factors and help state and local partners develop effective violence prevention programs.

And while we know that the majority of Americans who struggle with a mental illness are not violent, we're working to make it easier for young people, adults, and families struggling with mental illness to seek help. I encourage all of you to engage in our community conversations that are part of our effort to let people know that treatment works and that recovery is real.

The President hasn't given up on pushing forward on commonsense gun violence prevention efforts. You shouldn't either. We need your voices. We need your action. Now is the time.

And now is also the time to fulfill a promise of equality for tens of millions of Americans denied a basic freedom and opportunity to live a healthy life. From day one of this presidency, we've worked with all of our assets to reduce the health inequality that Dr. King called the most shocking and inhumane form of injustice of all.

We're investing in community health centers and workforce programs to bring thousands more doctors and nurses to the neighborhoods where they are most needed. We're recruiting public and private sector partners to help promote active lifestyles and healthy eating through the First Lady's Let's Move initiative.

I was at the White House with Valerie Jarrett yesterday to observe the third anniversary of the President's National HIV/AIDS Strategy. It has given us a new sense of direction to our fight against the epidemic, focusing more resources on the communities that are hardest hit – many of which are communities of color.

But there's probably no bigger step toward improving the health of communities of color than expanding access to affordable health coverage – and that's what the Affordable Care Act does.

Now, no matter what you're hearing out there, let's remember some facts. The debate in Washington is over. The Supreme Court has issued its decision. The people have spoken. President Obama was re-elected.

And to paraphrase Stevie Wonder, the Affordable Care Act is signed, sealed, and it's delivering.

More than 7 million African Americans with private insurance can now get preventive services for free – including blood pressure and cholesterol checks, cancer screenings and flu shots. All of this helps reduce the incidence of diseases – many of them preventable – which disproportionately affect communities of color.

Four and a half million elderly and disabled African Americans on Medicare – your grandmothers and grandfathers – now have access to free wellness visits and more affordable prescription drugs.

More than 500,000 young African American adults – your sons and daughters – who were previously uninsured are now covered by their parents' plan.

For all the women in the audience, this is a new day! Being a woman will no longer be a pre-existing condition for insurance companies! No longer will women have to worry about being denied care or charged more because of a pregnancy or breast cancer. Millions more women will have new options for coverage – already women now have access to critical services like contraception and cancer screenings with no extra out-of-pocket costs.

When we talk about health insurance, it's not just a card in a wallet. It's security. It's peace of mind. And it's not just about "insurance." It's also about "health."

So the first thing that people should know is that the health law is making that health coverage stronger for the majority of Americans who have it already – and that's about 85% of all Americans.

And the second thing to know is that for the 15% percent of Americans who don't have coverage at all, or for Americans who buy their own insurance right now and aren't happy with it, they'll have better options come this fall.

Beginning October 1, a new Health Insurance Marketplace will open for enrollment in every state, with benefits starting in January 2014.

All plans in the Marketplace must cover an essential set of benefits, including doctor visits, prescription drugs, and mental health services. Discrimination based on gender or pre-existing conditions, like diabetes or cancer, will be outlawed. And many individuals, families and small businesses will qualify for a break on the costs of their monthly premiums.

For the first time in history, insurance companies will have to compete for business based on price and service – not lock out, dump out, or price out of the market anyone who might get sick. Those days are over!

To enroll in the Marketplace, all you have to do is visit HealthCare.gov, where you'll find simple information that helps you find a plan that fits your budget.

HealthCare.gov will also help people find out about Medicaid coverage in their state – and this is another critical piece of the puzzle to ensure more Americans get the care they need.

Some of you live in states where the Governor and legislature have already decided to expand Medicaid. The door is open and we will keep working until all states sign up.

That's because if Medicaid isn't expanded in more states, millions of working people and some of our most vulnerable families could be left with no source of affordable health coverage. And speaking as a former governor, since the federal government will pay 100 percent of the costs for the first three years, and at least 90 percent thereafter, this deal is too good to pass up.

But here's the key point. Just because people have the opportunity to get new coverage – whether through the Marketplace or Medicaid expansion – doesn't mean they know about it.

A big share of the uninsured is young and healthy. If you have young adult children like I do, you know that getting health insurance is not always their first priority. I sometimes don't know what their first priority is, but it certainly isn't insurance.

But we also know there are people who have been uninsured or underinsured for so long that they simply don't believe that affordable coverage will ever be within reach.

They are busy working hard or going to school. They worry about the health of the ones they care for instead of their own. Each of you probably knows someone who wants that weight off their shoulders – who wants that new coverage so they can live, work, and reach their dreams.

And in less than three months, we have the chance to help our family, friends, and neighbors finally find that security and peace of mind. But we can't do it alone. We need your help.

To get ready for October 1 when the Marketplace opens for enrollment, you can visit HealthCare.gov today to sign up for information and updates.

It's not your typical government website – it's much easier to use and understand. And it's the best way to find out about those benefits that will be available as early as January 1, 2014. There's a web chat feature to help answer your questions – just like what you see when you're shopping online. And if you don't have access to a computer, there's a 24/7 customer call center ready to answer your questions in 150 languages.

And know that we're doing everything we can to help spread the word. We're partnering with local libraries and community health centers to help people sign up and enroll in October. We're supporting efforts to hire people who will work in many of your communities to educate your friends and neighbors about their options. Anton Gunn from our Department spoke at your Health Leaders Luncheon yesterday on ways your local branches can get involved.

And I've been traveling the country along with other senior health officials, visiting churches and holding town halls with African American community leaders to reach as many people as we can.

We know lots of people need information. They just want to know where to go to find it. And you can make all the difference!

In this room are educators, community leaders, parents, and grandparents. We need your voices and your help with outreach and education. So start spreading the word.

Download toolkits and customize flyers to hang up in local businesses like restaurants, barbershops, and beauty salons. Share them with your fraternities and sororities.

Some of you are health leaders: doctors, nurses, and counselors: Educate your patients about their rights and new coverage options. If you're a pastor or first lady, a deacon or a health ministry leader, few voices are more powerful than those from the ones we trust – use your voice to educate and motivate.

After 100 years of conversation about health reform, change is finally coming. And we only get this chance once in a lifetime. We need the NAACP to continue to be a champion for coverage to help remove one of the most persistent forms of inequality once and for all.

The Affordable Care Act is the most powerful law for reducing health disparities since Medicare and Medicaid were created in 1965, the same year the Voting Rights Act was also enacted.

That significance hits especially close to home. My father was a Congressman from Cincinnati who voted for each of those critical civil rights laws, and who represented a district near where the late Reverend Fred Shuttlesworth lived and preached.

The same arguments against change, the same fear and misinformation that opponents used then are the same ones opponents are spreading now. "*This won't work*," "*slow down*," "*let's wait*" – they say.

But history shows that upholding our founding principles demands continuous work toward a more perfect union. Bridging the meaning our inalienable rights to the realities of our time requires speaking up and standing up for them. And it requires the kind of work that the NAACP has done for more than a century to move us forward.

You showed it in the fight against lynching and the fight for desegregation. You showed it by ensuring inalienable rights are secured in the courtroom and at the ballot box. And you showed it by supporting a health law 100 years in the making.

With each step forward, you said to forces of the status quo, "*This will work*," "*we can't slow down" We can't wait*," "*we won't turn back*."

And those voices of progress form the echo we hear and honor this year.

They echo from church bells rung at midnight 150 years ago to educate our nation of a people's emancipation. They echo from a speech on our nation's mall 50 years ago next month about the promise of our nation's dream. And they still echo and guide us today in a second term of a historic presidency.

So let us seize this moment. We can't slow down. We can't wait. We won't turn back.

We move forward.

Thank you.

Exhibit J

Weldon Amendment, Consolidated Appropriations Act, 2009, Pub. L. No. 111-117, 123 Stat 3034

United States Public Laws
111th Congress – First Session
PL 111-117, December 16, 2009, 123 Stat 3034
Consolidated Appropriations Act, 2009

. . .

TITLE V
GENERAL PROVISIONS

. . .

SEC. 508.
. . .

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.